THE COMMUNITY MEDICINE SPECIALIST IN THE BRITISH NATIONAL HEALTH SERVICE

THE EXPERIENCE IN WALES---1974

ARBENNIGWR YN TECHYD CYMDEITHASOL CYMRU--1974

Bruce Walter Beck

1975

THE COMMUNITY MEDICINE SPECIALIST IN THE BRITISH NATIONAL HEALTH SERVICE THE EXPERIENCE IN WALES ---1974

ARBENNIGWR YN TECHYD CYMDEITHASOL CYMRU -- 1974

0
0

BRUCE WALTER BECK

0
0

SUBMITTED TO THE FACULTY OF THE DEPARTMENT OF EPIDEMIOLOGY AND PUBLIC HEALTH, YALE UNIVERSITY SCHOOL OF MEDICINE IN PARTIAL FULFILLMENT FOR THE DEGREE OF DOCTOR OF MEDICINE AND THE DEGREE OF MASTERS OF PUBLIC HEALTH.

1975

TABLE OF CONTENTS

ACKNOWLEDGEMENTS

I am indebted to Dr. George Silver for his kind and patient guidance in this endeavor. In addition, I wish to thank Professor C.R. Lowe for his efforts as my sponsor in Wales, Dr. W.C.D. Lovett for Both the professional and personal help he extended to me in Wales, and Professor A.L. Cochrane for his interest in this project. Thanks also go to Dr. Rosemary Stevens for invaluable feedback on this paper.

I would also like to acknowledge the warmth I experienced from the Welsh people themselves. It is in deference to them and their uniqueness that the title of this study is in both English and Welsh.

DEDICATION

TO

ROY AND CLAIRE

I. INTRODUCTION

In April 1974, Britain embarked on a new course in its National Health Service (NHS). After 25 years of experience and change in British health care, the tripartite NHS (composed of Hospital, Public Health and General Practice sectors) was reorganized in an attempt to integrate and coordinate existing services.

Reorganization has had two major aims: 1) improvement of standards of patient care in areas neglected by "mainstream" medicine in the past, such as geriatrics; 2) the introduction of a unified administration of management controls to make the NHS more integrated and effective. [1.] The emphasis throughout the structure is on collective decision-making and responsibility in an effort to transcend the traditional roles of Hospital, Public Health and General Practice. Unification of the NHS should make it easier to plan total health needs, whereas in the past planning has occurred separately in each of the tripartite components.

Integration of the services demanded a wider perspective from health professionals than had been required under independent services in the tripartite structure. Reflecting that the Public Health officers have evolved to a point where many of their functions are outmoded or estranged from the mainstream of medicine, the reorganized NHS has eliminated them and has created a new medical specialty: the Specialty of Community Medicine. As the principal agent for the planning, monitoring, and evaluation of the integrated health programs, the Community Medicine Specialist is one of the potentially

far-reaching changes in the reform initiated in 1974. As the Community Medicine Specialist symbolizes the philosophical and practical reform in reorganization, the degree to which this health professional succeedswill be important in assessing this approach to health care.

This study describes the emergence of the Community Medicine Specialist (CMS) in Wales in 1974. It will focus on the evolution of the CMS by examining 1) the background of the CMS in Wales; 2) his fulfillment of stated responsibilities; 3) the short-term and long-term training given to the CMS.

II. BACKGROUND

A. PRIOR TO THE NHS

Britain has a long history in the development of government health services, dating back to the turn of the century at least. Between 1890 and 1910, there were developments in ways of providing and paying for medical attention. The first definite call for a State-operated medical service occurred in 1908 in the "Minority Report On The Reform Of The Poor Law". Then, despite a struggle with the medical profession, a system of National Health Insurance was adopted in 1911. A Royal Committee Report on NHI in 1926 noted that the insurance scheme had become an accepted part of life and concluded "the ultimate solution will lie, we think, in the direction of divorcing medical service from the insurance system and recognizing it along with all other Public Health activities as a service supplied from public funds."[2.]

Once established, National Health Insurance evolved over the years to cover gradually more people. In 1919, a Minister of Health was created. Then in 1931, the poor-law hospitals became administered by municipalities, and by 1939 virtual national hospital service was established to meet the demands of war.

The British Medical Association, respresenting the medical profession, had moved closer to the Labour Party by 1942, and the Report of the Planning Committee accepted the need to "provide a system of medical service directed towards the achievement of positive health

of the prevention of disease, and the relief of sickness."[3.] 1942 also saw the publication of the Beveridge Report which surveyed the various provisions of NHI and recommended "a health service providing full preventative and curative treatmentof every kind to every citizen without exceptions, without remuneration limit and without economic barrier."[4.] Lord Beveridge proposed a "comprehensive National Health Service (that) will ensure for every citizen there is available whatever medical treatment he requires, in whatever form he requires it."[5.]

In 1944, the Churchill Coalition Government published a White Paper (of intent) of proposals for implementing the Beveridge Plan. It was much the same NHS that was implemented: a fully comprehensive and free health service financed largely out of general taxation, with neither patients nor doctors compelled to use it. The BMA polled its members at this time and found that although 60% approved of a free comprehensive NHS, 78% were against control they envisioned by local authorities and a majority were against the White Paper.[6.] This vein of feeling, together with the lobbying power of the BMA, assured certain concessions in the future structure of the NHS. In 1946, with compromises worked out, the National Health Service Act was passed, and in 1948 commenced operation.

B. THE NHS AND REORGANIZATION

In 1948, even though the health services rendered by the NHS were revolutionary, the shape of the structure to implement them was very traditional. Sir John Brotherston writes:

> In fact, in 1948, we took over a traditional tripartite

> set of arrangements for running our service(Hospital General Practice and Public Health) and by imposing statutory definitions on previously fuzzy traditional boundaries, the NHS increased the separateness of the three parts. Every school boy knows that all Gaul is divided into three parts; so too is our NHS. 7.

Table I shows the structural organization of the original NHS. The tripartite set of arrangements mentioned by Brotherston refer to the three administrative parts of the NHS: 1) Hospitals(and Specialists) were governed by Hospital Boards with their own regional boundaries. Over the years, the Hospital sector became the most powerful lobby for the NHS budget. It became the arena where most of the money, innovations, and prestige accumulated. 2) Public Health services were administered by the Local Authorities. These services included maternal and child health, environmental health, home nursing, ambulance, screening, and communicable disease. Preventative medicine, as in this country, became thwarted as a sideline to curative medicine. 3) General Practice--or Primary Care--was administered by the Local Executive Council, which unfortunately did not have the same boundaries as either of the above sectors. GPs in the original NHS were given the most autonomy and were allowed to remain independent contractors to the NHS. However, they also suffered from the tripartite structure in terms of being an ineffective lobby for financial aid and improvement.

Attempts over the last 25 years to create a mixture of Hospital, Primary Care, and Preventative Medicine have always run into the difficulty of the necessary joint-decisions and trade-offs between the three structures. Thus, the importance of the boundaries outlined

above came to bear not only in administrative duties, but also in terms of sovereignties and vested interests who sought to strengthen their own domain.

The cummulative frustrations of a health service dedicated to the ideals outlined by Lord Beveridge but handicapped by an inadequate structure, led to public discussion of reorganization in the 1960's. The Porrit Report of 1964 was the first overt advocation that integration of the local health services was necessary.

Then in 1968, the Labour Government issued the first of two Green Papers(for public discussion) of its intent to integrate the tripartite structure. In 1970, the second Green Paper was published and noted that two significant decisions had been made: 1) the NHS would not be administered by local government, but by Area Health Authorities directly responsible to the Department of Health and Social Security (formerly the Ministry of Health); 2) the number and area of these Area Health Authorities (AHAs) would match those of local government. i.e. for the first time geographic health and government boundaries would be coterminus.

The subsequentConservative Government concurred with the need for integration, and in November 1970, the Secretary of State declared in the House of Commons:

> The Government intend to unify the administration of the NHS--Legislation will bring the change into effect at the same time as alterations are made in the structure of local government. The NHS will be administered by Health Authorities outside the government working closely with local authorities. 8.

Momentum picked up, and in 1971 the British Government issued a Consultative Document on NHS Reorganization which stated:

> Traditionally separate and distinct elements---hospitals family practitioners services, and community care---- (should be responsive to) what the public needs and what the Health Service demands....organized so that its separate parts are planned and operated, not in fragments but as a whole. 9.

The Consultative Document listed April 1, 1974 as the proposed date for the reorganized Health Service to commence, and gave impetus to delineating the exact form by which it would be administered. In 1972 the Hunter Report and the "Grey Book" appeared outlining proposals for the managerial structure of the NHS. In Wales, a "Red Book" on managerial arrangements was also issued as the blueprint for the reorganized NHS in Wales. Finally, in 1973, the NHS Reorganization Act was passed by Parliament so that integration became a reality by April 1974. In the interim, the Health Service began readjusting itself to the changes in staff and structures it would undergo.

The structure of the new NHS was emerging. New health boundaries and a new system of coordinating existing disciplines were created. The emphasis was focused on an administrative structure that could accomodate a new way of health care delivery.

Reorganization involved not only a bureaucratic shuffling of positions, but also a reorientation to health care delivery. The NHS itself is in charge of delivering health care; hence it can act to generate services for those in greatest need, as measured by social or economic indicators. This aspect accounts to some extent for the emphasis in reorganization on preventive and community services; the

traditional methods of care failed to plan innovatively for the needs of such groups or populations of people as the chronically ill, the aged and the mentally handicapped. [10.] For example, although 67% of the NHS is actively concerned with the care of these services, they receive only 35% of the resources. [11.] (For more facts and figures on the "Special Needs Groups" in Britain, see the appendix) A prime motivation was to alleviate the needs of these people. One of the major aims, therefore, was to facilitate a "population-oriented" health care system.

There is both philosophic and practical significance to this approach to integration, for it recognized that health services needed to center around the patients themselves. Brotherston notes:

> The most important component of a health care system is its population of patients, and an appropriate medicine approach seems an essential requirement without losing in any way our sense of the importance of the individual or the doctor-patient relationship. We have to learn to study the needs of populations at risk and to meet their requirements. 12.

This concept of population medicine is inherent in reorganization, and seeks to transcend the various disciplines within medicine----- something difficult if not impossible to accomplish given the competitive nature of the tripartite structure.

The approach, then, was to organize the NHS (and the medical disciplines of which it was composed) around populations of people. In terms of medical administration and implementation of this idea, the team approach became the cornerstone of the new NHS. This multi-disciplinary team, composed of clinicians, nurses, community

physicians, and administrators would work in a geographic framework (district or area). They would effect collective decision-making and would bear collective responsibility for the delivery of health care to their locale. Who is responsible for coordinating the efforts of these teams as a population-oriented mentor? The Community Medicine Specialist.

The structure of the new NHS follows from the approach outlined above. Table II illustrates the new structure in Wales, emphasizing the hierarchy of corporate function. The old sectors have been abolished but the overall responsibilities provided by the NHS remain the same:

a) Hospital and specialist services formerly administered by the Regional Hospital Boards.
b) Family doctor, dental and ophthalmic services transferred from the Executive Councils.
c) Personal health services previously run by the Local Authorities through their health committees. These include:

*Ambulance services	*Home Nursing/Midwifery
*Epidemiologic surveys	*Maternity/child care
*Family Planning	*Vaccination/immunization
*Health Centres	*Other Preventative services
*Health Visiting	

c) School Health services. 13.

As the table implies, there are two geographic entities which act as operational authorities in the new NHS: Area and District.

The districts are the smallest sized units for which a full range of health services (listed above) can be rendered and integrated. These "natural" districts are based on hospital catchment areas; i.e. centered around a population's use of existing hospital and community services. This gives them the advantage of being self-contained

and a geographic entity in terms of health services. The coordination and planning of services for the district would be the function of the District Management Team (DMT). Each DMT is composed of an administrator, a nursing officer, a finance officer, two clinicians (who represent local hospital consultants and general practitioners) and a community physician(a Community Medicine Specialist). Each district is contained within an Area Health Authority (AHA), and is responsible to it as are the individual members of the DMT to their AHA counterparts.

At the area level the AHA is the basis for statutory authority and planning.[14]. Their boundaries are coterminus with those of the new counties or local authorities. They employ most of the staff of the NHS, although the GPs as independent contractors maintain a direct relationship to the DHSS in the form of Family Practitioner Committees. The AHA is responsible for the coordination and planning of services in the area. In the AHAs where there are more than one district, this requires a close working relationship with the districts. The Area Medical Team (AMT) has a membership similar in composition to that of the DMT. The CMS at this level whose role is analogous to the District Community Physician is called the Area Medical Officer. Other Community Medicine Specialists may exist at the area level by appointment of the Area Medical Officer(AMO) . These CMS are called Area Specialists in Community Medicine (SCM) and concern themselves with specific population issues of the AHA(e.g. a SCM concerned with Child Care). In Wales, the AMT is responsible to the Welsh Office, and thereby to the DHSS.

The Welsh Office is concerned with general health policy, overall planning and allocation of resources to the AHAs as well as advice and coordination of the NHS in Wales. [15.] It is responsible to the DHSS for Britain. The DHSS, at the top of the hierarchical ladder, retains the ultimate responsibility for policy decisions affecting the NHS.

Within this structural context, the Community Medicine Specialist is present at every level, occupying a pivotal role in the health services the new NHS provides.

C. THE COMMUNITY MEDICINE SPECIALTY

As noted above, the attempt to integrate the various services of the NHS on a population-oriented basis requires astute management by people oriented to community medicine. In response to this need, the Faculty of Community Medicine was created in 1972. The Specialty of Community Medicine is defined in the Standing Orders of the Faculty:

> Community Medicine is that branch of medicine which deals with populations or groups rather than individual patients. In the context of a national system of medical care, therefore, it comprises those doctors who try to measure accurately the needs of the population, both sick and well. 16.

In terms of existing disciplines, the Specialty would have "special knowledge of the principles of epidemiology, of the organization and evaluation of medical care systems, of the medical aspects of administration of health services, and of the techniques of health education and rehabilitation." [17.] In this respect, it incorporates

the study of morbidity and mortality with the determination of needs for preventive and medical care services.

The membership of the Specialty reflects this broad aim; together with the academic side of social medicine, is joined a group of physicians who are engaged in public health and health services administration. Professor A.L. Cochrane, President of the Faculty, is a noted epidemiologist with a background rich in experience in health care.

The Faculty itself is "to function as a faculty within the Royal College of Physicians in the United Kingdom, sharing their efforts for the advancement of medical knowledge." [18]. More specifically, the Faculty's prime objectives are:

a) to promote for the public benefit the advancement of knowledge in the field of community medicine.

b) to develop community medicine with a view to maintaining the highest possible standards of professional competence and practice and to act as an authoritative body for the purpose of consultation in matters of educational or public interest concerning community medicine. 19.

The Faculty has defined the CMS as a physician who possesses the skills of " a basic understanding of clinical practice, a familiarity with statistical methods, the relevant aspects of the social sciences, and the principles of administration and mangement." 20.

Who, in fact, is this Community Medicine Specialist ? In many ways, he is a Medical Officer of Health (MOH) or public health officer. Britain has known the MOH for over a hundred years. At first, his functions concerned mainly environmental hazards, especially transmitters of infectious disease. Gradually, this widened to include mental illness, infants, sick school children, and after 1929 the full range of hospital services. In 1948 and the NHS, the MOH lost his responsibility for the hospital service, but gained respeonsibility for nursing, health centres, and ambulance service. The traditional functions of the MOH, however, have evolved to a point where he has become separated from mainstream medicine and the prestige of his hospital and primary care colleagues. Medical technology has brought communicable disease under control; the MOH became a consultant in a limited sector of preventative medicine.

All this is not to say that the MOH did not concern himself with community medicine. However, even though he supervised the health of his community, there was no official means for him to assimilate the needs of his area or to translate these needs into the clinical mainstream.

The philosophy inherent in the community approach to medicine links curative to preventive medicine. By eliminating the MOH and creating the CMS, the British acknowledged his new function as transcending existing structures and being oriented to the community instead. Integration and the creation of a specific Specialty should facilitate the role of the CMS.

What is the role of the CMS ? According to the Hunter Report and the Grey Book, the CMS has the following responsibilities:

a) Procurement and Interpretation of Health Information
b) Planning of Health Services
c) Management of Health Services
d) Advice and Assistance as a Consultant

Health Information, the data base on which decisions are made, represents the cornerstone of the Specialist's efforts. Utilizing expertise in epidemiology, he is responsible for a systematic investigation of the health situation of the community. Besides traditional statistical information, he will have a role in collecting information and analyzing different approaches to health care delivery. To this end, he has the collaboration of local government services. The typical "profile" information will include figures on 1) Demography 2)Morbidity and Mortality data 3) Physical rsources 4) Manpower 5) Needs and Demands for Services. Some of the respresentative figures for such health information are discussed in the Appendix.

Planning involves assessing the resources of the domain and allocating them according to the priorities of the team. By formulating policies in relation to the needs of the population, the CMS will serve as the primary health spokesman for change in his area.

Management of health services entails two main tasks for the CMS: 1) "to monitor and to evaluate the operation of all health services, including their working relationships with related services provided by central or local government" [21]. This is not intended to be a clinical audit or to interfere with the clinical

audit or to interfere with the clinical autonomy of the physicians, but to assess the effectiveness of projects and make alternative suggestions. 2) "to promote improvements in organization and delivery of health services with available resources." [22.] For instance, this might entail encouraging more general practitioners to form group practices centered around health clinics. In addition to the above tasks, the CMS is responsible for the coordination of preventive care services such as immunization, screening, health education etc.

Advice and assistance relates to the CMS role as a consultant to groups and agencies outside the NHS as well as to colleagues within the Health Service. Such groups would benefit from the CMS advice on proper environmental hygiene, communicable disease control, health education and delivery of social services. In addition, by giving advice to community groups as well as health boards, the Specialist will serve as a patient advocate from a professional perspective. [23.]

What will be the training for the Specialist ? As indicated, the CMS is seen as superceding the MOH, so therefore in the interim until specific training programs produce enough Specialists, it is likely that the CMS will be recruited from existing MOsH and Hospital Board personnel. Thus, for now, training will be dictated by whatever background the individual has plus the short-term orientation he has received. In the long-term, the question of training is important; the Hunter Report envisions a variety of disciplines such as epidemiology, statistics, social services, and mangement. Anumber of such programs, supported by the Faculty of Community Medicine, are underway.

III. THE SITUATION IN WALES

Wales, with a population of 2.7 million, was divided into eight Area Health Authorities with a total of 14 districts. The geographic location of these health boundaries is shown in Figure A. It should be noted that only five of the AHAs contain two or more districts; three AHAs are so-called "single-district" areas. The AHAs and the counties are coterminus, but the districts do not always parallel government boundaries.

WELSH REORGANIZATION AND THE CMS

Reorganization in Wales resembles that of England in most respects but differs in requiring only two tiers of administration (area and district) to deal with its comparatively small population. Within these two tiers, the CMS functions in three main capacities: the Area Medical Officer (AMO), the District Community Physician (DCP), and the Area Specialist in Community Medicine(SCM). The role specification for each is outlined in the Red Book on "Management Arrangements for the Reorganized NHS in Wales" and will be discussed below.

The AMO is a member of the Area Team and works at the issues of community medicine at the area level. According to the Red Book, his spheres of activity are:

1)Health Information -- he keeps up to date on the health needs of the area's population and initiates special studies for research into these needs. For example, if

his area contained a large population of retiredmine workers, he might initiate a study into what medical needs they have.

2) Planning -- With the data base at his disposal, he recommends are operational health care policies. He forms a liaison with the district in drawing up guidlines and priorities for the District Team; he challenges district plans and provides specialist planning assistance to the DCP.

3) Management -- He meets with the DCPs to review information and achieve mutually agreed goals in health care; he is responsible for monitoring and coordinating the efforts of the districts in his area. In addition, he is responsible for managing the health services of the area such asspecial needs groups, occupational health, screening, and health education and ambulance services.

4) Medical Services -- He provides certain services to local government in the form of advice on environmental or school health.

5) Advice and Assistance -- He gives advice as a Specialist to bodies outside the NHS (such as Education Authorities, or Social Services Dept) as well as to bodies within the NHS (AHA and the AMT).

The DCP, as a member of the District Team, has the following main responsibilties:

1) Health Information -- He collects and maintains a health profile of the district.

2) Planning -- He formulates plans, after review of the pro- of services within the district, implements plans, and

provides surveillance of the effectiveness of the plans.

3) Management -- He coordinates the health services provided by the clinical medical officers concerned with school health, vaccination, screening, and immunization; he performs liaison with the social services.

4) Medical Services -- He serves as an advisor in environmental and school health, as well as performing communicable disease control.

5) Advice -- He advises hospital and primary care colleagues as a Specialist. He also provides assistance to Community Health Councils and various voluntary bodies.

The Area Specialist in Community Medicine (SCM) is on the staff of the AMO, and is concerned with a sub-specialty within the community medicine of his area. These sub-specialties are : 1) Planning --providing medical expertise in the preparation and implementation of plans; 2) Epidemiology and Statistics -- collecting, analyzing, and advising on health care and demographic statistics as well as carrying out special investigations; 3) Manpower -- planning for the most effective use of medical manpower, facilities, and training programs; 4) Child and School Health; 5) Special Needs Groups -- assuring adequate health care for people at special risk. In some of the areas, all these SCMs will be present; in others, because of less population to be covered, the full complement may not appear and more than one subspecialty may be covered by one SCM.

The number of positions in Wales for the CMS include one AMO for each of the 8 areas, one DCP for each of the 14 districts, and 18 SCMs scattered among the areas. In addition, there are positions for CMS to function at the all-Wales level in the Welsh Office.

The procedure for staffing these posts is beyond the scope of this study. In the year preceding the deadline of April 1, 1974, there was much upheaval in a formerly secure profession, as doctors suddenly found their old jobs gone and special scrutiny given to staffing the new roles. As there were less new positions in community medicine than in the old hospital and public health management roles, a doctors's position was by no means certain; a curriculum vitae had to be submitted and an interview arranged. Due to the stringently high standards the NHS placed on the CMS, not everyone qualified for the Specialist posts, much less the positions in the sub-specialties. The result was that some doctors were disappointed, and some posts were left unfilled by April 1974.

IV OBJECTIVES-METHODOLOGY-RESULTS

A. OBJECTIVES

This study is intended to describe the emergence of the Community Medicine Specialist in Wales in 1974. It will focus on his position at an area level and a district level with the following aims:

I. Background --

a) Obtain background information on all the CMS within the NHS in Wales, including such aspects as date of appointments, age, sex, professional and geographical background, and exposure to reorientation courses in an effort to define factors that may affect the outlook of the CMS in his new role.

II. Function --

a) Define the actual responsibilties of the CMS measured against the ones stated in the official job description to see what his self-concept is in his new role, and what aspects of his job are occupying most of his time in the early days of reorganization.

b) Identify some of the factors that might hinder his effectiveness in his stated responsibilties, and see whether these might change over time.

III. Education --

a) Define the specific training for this job, including the short-term reorientation given to the present

specialists as well as the formal training curricula proposed to train the specialists of the future.

B. METHODOLOGY

A period of 8 weeks was spent in Wales gathering background data and interviewing Spcialists. During this time, work was co-ordinated with the Department of Social and Occupational Medicine at the Welsh National School of Medicine and greatly facilitated by the Welsh Office.

I. Background --

a) Data on numbers of specialists, time of appointment, age, sex, degrees and dates of degrees, professional and geographic background (i.e. in which part of the NHS they had chiefly worked prior to reorganization) were all made available by the Welsh Office.

II. Function --

a) Once the backgrounds of the Specialists were amassed, it gave enough perspective to approach the question of function. There essentially three levels of CMS in the Welsh NHS: AMO, DCP, and SCM. At the time of the project, which was only two months after the inception of the Health Service, all 8 of the AMOs and 13 of the 14 DCPs had been appointed, but there were still 7 of the 18 posts vacant at the SCM level. Therefore, it was decided to approach the question of function at the level of AMO and DCP only.

A simple questionnaire was devised, listing the official functions as listed by the Hunter Report, the Grey Book, and the Red Book of job descriptions.for each of the two levels under consideration. The questionnaire was structured so that the recipients were asked to rank numerically the absolute importance of time spent now and the value ascribedto each function listed on a scale of 1 - 5, with #1 being the highest and #5 being the lowest degree of importance. Then, the same exercise was performed again for the amount of time and value they envisioned in the future. Thus, it was hoped to gain an idea of the various weights each function carried in the early days of reorganization and to gain an insight of how a couple of years might modify it. These forms were distributed to all 8 AMOs and 9 of the 13 DCPs. Arrangements were made at the same time to interview the recipients at a future date.

b) The actual interview consisted of going over the questionnaire with the Specialist and answering any questions he had about it. Then a period of discussion follwed concerning: (1) how his professional background may have affected his present outlook; (2) what problems posed the greatest difficulty for him in his new role and what he saw as his first priority in overcoming them; (3) what his experience was with the reorientation, and whether in retrospect he would change its character, content, or timing; (4) his view towards continuing education for himself at the present, and the training programs that would be turning out the CMS of the future.

III. Education --

a) An attempt was made to define the actual programs of reorientation (giving the one in Wales as an example) and relating the Specialists' comments to its efficacy. This was accomplished by abstracting from the syllabus and talking with Professor Lowe, the organizer of the Welsh program.

b) Finally, the curricula of the formal training program for the future CMS was defined. This material came from talks with Professor Cochrane, President of the Faculty of Community Medicine and from a White Paper the Faculty put out.

It was felt that the above methods gave the greatest latitude in defining the background of the CMS and a working idea of his role two months after NHS integration. The study itself is descriptive; there are no hypotheses being tested. Yet this approach plus a subjective type of interview technique allowed many consistencies to emerge.

C. DATA RESULTS

In each category (Background, Function, and Education) results are presented in the form of accompanying tables. A short discussion of the results follows each presentation, highlighting aspects that will be considered later in a general discussion.

I. Background -- CMS Profiles

The profiles compiled of the CMS in Wales are broken down into components in Table III. The information shows some consistency with information gathered on attitudesduring the interviews. The data will be presented in three categories:

#1 Appointments/vacancies: As previously mentioned, not all the posts have been filled. In general, as seen in the figures on the time of appointment, the AMO and DCP posts were given priority in the selection procedure, the majority being filled prior to 1974. The SCM level shows both the highest number of vacancies and the more recent dates of appointment. It is lack of qualified applicants that is cited for the reason for the vacancies. Yet the mere lack of SCM appointments is also hampering the efforts of the AMO and DCP in performing their statistical and planning functions. The one DCP post vacant is being covered by the AMO(thus coloring the distribution of his time and value in his stated function).

#2 Age/Qualification/Sex: As the figures indicate, the average age of the AMO is highest at 49, followed by the DCP at 48. The SCMs as a group comprise the youngest comprise the youngest level of the specialty within the Welsh NHS. All three groups of CMS show a wide range of age distribution which spans over 20 years between the youngest and the oldest in each category. The year of degree qualifications adhers closely to the age data with respect to both mean and range of dates; the AMOs as a group obtained their educational background earliest. All the AMOs and DCPs are male, and only 2 of the 11 SCMs

are female. These figures indicate mainly middle-aged males hold jobs as Specialists in Wales at this time.

#3 Professional Background: In every category of CMS, there is a predominance of Specialists from the former Public Health sector. Most of the CMS also worked in Wales prior to reorganization. There are several Specialists who have had experience in more than one sector, but for the purpose of determining outlook, only the principal post held prior to reorganization is examined. The highest proportion of CMS with hospital experience occurs at the AMO level. This fact may have some correlation with the AMO being the most powerful of the CMS listed and having to deal most often with hospital problems. However, the fact remains that public health experience predominates among the CMS in Wales. This may prove significant in their short-term efficacy, for most of the problems and budget requiring attention in 1974 relates to the hospitals.

II. FUNCTION

For the results of the averaged questionnaires, see the adjoining Tables IV and V. A short discussion of each part will be divided into AMO and DCP sections, following which an attempt will be made to draw together the relevant part of the questionnaires with that information which preceded this section. Numerical ranks for time and value in the questionnaires are:

5 = very little time or value
4 = less than average " " "
3 = average " " "
2 = greater than average " " "
1 = considerable " " "

AMO QUESTIONNAIRE

#1 Provision of Health Information ---

a) Epidemiology: As the figures show, most of the AMOs placed a high value (2.0) on Epidemiology (both the traditional communicable disease and the new profiles in population disease), for it is on this foundation they are called upon to answer questions on existing modes of health care delivery as well as improving it. Normally, they expect to delegate this function to a SCM a merely keep appraised of the figures. However, few qualified statisticians make this function difficult to delegate to a SCM at the present time, and the AMOs are finding they are spending a cosiderable amount of time on collecting and analyzing health data (time = 2.3). In the future, however, the AMOs see this function requiring less of their time (2.6) but becoming more important (1.3) as plans are initiated.

b) Manpower, under health information, was interpreted as the staffing and organization of the NHS. This received high value from the AMOs (now = 1.4 and future = 1.5) mostly in relation to reorganization and the problems of establishing a bureaucratic structure. Therefore, although much time is being spent now (1.9), they expect to spend less of their time (3.1) on this function in the future.

c) Services were interpreted as information on existing medical services such as ambulance, family planning, and the various types of facilities at the AMO's disposal. Both time (1.7) and value (1.4) received high ratings, indicating that the AMOs placed a high priority

in establishing an organized network of services to carry on the work of the old sectors. Once again, they expect to spend less time (2.8) in the future on such activities as they delegate responsibility to others, but would continue to place a high value (1.8) on them.

#2 Policy Formulation and Planning ---

For the most part, the AMOs see themselves as primarily health care planners both now and in the future. The response to time spent now varied according to whether they had the staff to back them up (e.g. SCM in Statistics) as well as how much time they needed to acquaint themselves with existing services and personnel. Time of 2.8 does not accurately reflect these differences, and it should be noted that the distribution of responses was skewed. In the future, it is clear that the AMOs see themselves spending more time (1.8) and giving a higher value (1.5) in carrying out operations research (presently given a value of only 3.8). Likewise, formulating health policies will assume importance (1.1) and take a greater amount of time (1.2) in the future.

#3 Management and Coordination of Services

a) DMT performance: The response to monitoring this aspect of health care was relevant in only 5 of the 8 areas with two or more districts. In the other three there was no DMT to monitor. In the five multi-district areas, an average amount of time (2.6) was being spent with a greater than average value (2.0) attached to it. This takes the form of meetings anywhere between one and two weeks with the DCPs. A slight increase in both time (2.0) and value (1.8) is

seen in the future as communications become more established and policies become a greater part of the NHS in Wales.

b) Special Needs Groups, such as geriatric, mentally handicapped, etc., are provided a SCM in the Red Book, but for the most part much of the work is now being done by the AMO. This is relatively high priority for the AMO, receiving greater than average rating for both time (2.3) and value (2.1) for the present and slightly higher for the future (time =2.1 and value =2.4).

c) Social Services: Little time (4.3) is being spent in liaison with the social services department although it is given a higher rating of importance (2.6). Some of the reason behind this appears to be the fact that the social services have a separate administrative structure. However, as administrative roles become established, more coordination is hoped for in the future (time =3.2 and value =2.4).

d) Professional Relations and Communication: This 'function' was listed by the AMOs under 'other' in their mangement function as an important and time consuming aspect of reorganization. Both time and value were rated as approximately 2.3. For some of the AMOs this function was specific to the people within the AHA they were unfamiliar with (e.g. establishing contact with hospital personnel by a CMS with a public health background); for others, this role of establishing professional contacts required less time as patterns of communication had been established in prior posts. Thus, AMOs who were from Wales prior to reorganization were at an advantage. This aspect of management was expected to increase slightly in importance (2.0) but the time

was expected to decrease (3.0) in most cases.

#4 Medical Services to Local Authority:--

a) Again, two different administrative structures (NHS and Local Authority) are in process. Services presently offered through the DMT, such as advice on communicable disease, were given less than average time (3.4) and expected to occupy still less (3.8) in the future. This function was, however, given a higher than average rating for importance(2.4), reflecting a recognition for cooperation with the Local Authority.

b) The services offered through the area staff (e.g. SCM) show a similar picture to that above for the DMT with time presently 3.5 (future expected to be 4.0) and value of 2.6 (future = 3.5).

#5 Advisory as a Specialist---

a), b), and d): Social services, education authority, and voluntary bodies are all structures outside the NHS and were given low ratings for both time (4.8) and value (3.6). Little change is seen in the future.

c) and e): The AMOs clearly see themselves as Specialists in an advisory role to the AHA and the AMT ---namely their own structure within the NHS. It is at these levels they are now spending much of their time (AHA= 1.5 and AMT = 1.0). They envision spending at least as much time in the future as well (AHA = 1.2 and AMT = 1.1). It is at these levels that policy decisions discussed before will be made and implemented. The value ascribed to giving advice to these bodies was the highest recorded (1.0) both now and in the future.

DCP QUESTIONNAIRE

#1 Provision of Health Information ---

a) Environmental health received a low rating in terms of time spent (4.2) for the most part because the work is being carried out by a special Environmental Health Officer. Most of the DCPs saw th. themselves in more of an advisory capacity, or perhaps lobbying through the DMT for a policy that would have environmental implications. Value was given 3.9 and little change is seen in the future.

b) Maintaining the health profile was seen as an integral part of the new system of providing health care on a population-oriented district basis. Many DCPs indicated they would have to start from scratch in building a data base, while others would have an area SCM to assist them. Time spent inaccurately reflect these differences at 2.0. It was recognized that this aspect of medical information might have an integral part in the formulation of future policies, so that values were the same for now (1.3) and the future.

#2 Policy Formulation and Planning ---

a) The DCPs gave high ratings to both time (2.3) and importance (1.5) now to policy formulation for their districts. They expect their participation in this function to increase in the future (time=1.2 and value = 1.2) as the staffing allows them to complete their data base.

b) Special studies likewise received high ratings, for it would be through these area-assisted studies that they might lobby for the needs of their community. Time spent now was 2.4, mainly because

few studies have been initiated thus far in the fledgling NHS. This rating is expected to rise to 1.8 in the future. The value of 1.8 reflects a recognition of the importance of such studies as hospital demand and special needs groups in forming policy. This is expected to rise to 1.4 in the future.

#3 Management and Coordination of Services ---

a) Coordination and liaison of services in the effort of preventive medicine on a district level was presently occupying slightly less than average amount of time (3.2) for the DCP but most of the Specialists saw this aspects of their management function very important now (1.9) and in the future (1.8). Most indicated that programs for the future would involve liaison between preventive medicine and child health, and time is expected to go up to 2.1.

b) Child Health was treated similarly. Time spent now was 2.3 which corresponded closely with the value of 2.1. These values were see to remain much the same in the future.

c) Social Services were given slightly less than average amount of time (3.3) and roughly average amount of importance (2.9) for the same reasons given above for the AMO. Difficulty in liaison because of "the state of the reorganized Social Services Department" was expected to persist in the future, and time (3.6) and value (2.9) reflect this attitude.

#4 Medical Services to Local Authority ---

a) The low figures given to environmental health (time = 4.0 and value = 3.6) represent the factors discussed above with respect

to delegation of duties to another person. Little change is seen.

b) Communicable disease control is seen as an ongoing function from the old NHS, and although rated as important (2.4), it is given little of the DCP's time (3.6) both now and in the future.

c) Occupational Health was listed under 'other' and defined as the required certification given by the olf public health sector to certain employees (in terms of a physical and a chest x-ray) stemming from the large amount of mining done in Wales. This is one factor that the DCP values less (3.7) than the amount of time spent administering to it (2.9). For the most part, they saw this function occupying less of their time (3.5) in the future but not as much as some would prefer.

#5 Advisory as a Specialist ---

a) With respect to his advisory role to clinicians, the DCP was spending more time with the hospital specialists (3.0) than the GPs (3.7) with little change seen in the future. Values as a Specialist to the clinicians are approximately equal now at 2.2, but expected to diverge in the future (GP = 2.9 and Consultant = 2.2). One simple explanation for this divergence is the stronger communication links with the hospital consultants in the NHS than with the GPs who are still independent contractors to the NHS.

b) The Community Health Councils, the local means of involving a numbers of disciplines with input into the AHA, had not yet been formed at the time of the project, so therefore there are no figures for 'now'. In the future, the DCPs saw themselves involved in the CHCs in a remarkably split way: half of those solicited felt they

would be devoting a large part of their time and effort to the CHC, while the other half felt it was unimportant and would require little of their energies. Thus, the average figures poorly reflect the two poles of response at 3.1.

III. EDUCATION

Short-term: Reorientation:

Starting in 1972, four main centers emerged in England and Wales with a series of courses that focused on reorganization in an attempt to reorient personnel to the future make-up of the NHS. Virtually all the Specialists attended one of these programs:

a) At the Welsh National School of Medicine, 3 courses for 3 weeks ----organized by Professor C.R. Lowe.

b) In London, for approximately 6 weeks ---arranged by Dr. Roy Acheson.

c) In Manchester, for 2 weeks, then another week later on --- organized by Professor Alwyn-Smith.

d) In Birmingham, a series lasting 2 weeks ---arranged by Professor T. Mckeown.

As this study concerns Wales, and the majority of the Specialists attended the reorientation program at the Welsh National School of Medicine, a short description of this course will be given.

The course was entitled "A Course for Medical Administration" and was given September 4-22, 1972. It was attended by MOsH and

members of the Hospital Board in Wales. The general purpose of the course was to "implement the proposals made in the Hunter Report and to prepare medical administrators for their role in the reorganized NHS." 24. The structure of the course was divided into lectures and informal work-shop groups.

The composition of the course included discussion of the management functions of the forthcoming NHS, issues surrounding special needs groups(e.g. geriatrics), child health, screening, primary care, social service, medical economics and planning, and health information systems. In short, most of the functions now ascribed to a CMS and covered in the questionnaires of this study were included. The reactions to this approach will be discussed later.

Long-term: Training Program:

The Faculty of Community notes: "The recruitment of young doctors to Community Medicine has been unsatisfactory for many years for a number of reasons....recently because of lack of training posts and the uncertainty of career prospects during the period leading up to reorganization." [25.] The Faculty is entrusted with the task of outlining a training scheme and overseeing programs of study in community medicine. It serves as the mentor of community medicine.

Table VI shows the Faculty's proposals for a training scheme, comparing it with the training required for the clinical specialties. The training program outlined would take a total of 6 years of post-

graduate (after receiving a medical degree) experience, and would lead to a consultant level position. Of these 6 years, 1-2 years would be clinical training such as in hospital or general practice. Such training would be the same as for those individuals wishing to go into any of the clinical specialties. Following this period, the post-graduate (called a "Trainee" in the White Paper) would enter 2 years of "Early Specialist" training. During this time, courses would be taken to prepare the Trainee for Part I of the examination for membership into the Faculty of Community Medicine.

At the present, there are two main programs fulfilling the Early Specialist training requirements. Trainees have been participating in these programs since October 1973. One program is a full-time academic course offered by the London School of Hygiene and leading to a M.Sc. degree in 2 years. In this program, the first year would be spent in full-time coursework, and the second would allow the Trainee to prepare a research topic and carry it out.

The second program is a multi-university effort. This program takes 2 years to complete too, but takes a "modular" approach to coursework which entails academic coursework interspersed with in-service training. A timetable listing the participating universities and the duration of each academic module is given on Table VII. As the table shows, the Trainee spends a total of 11 weeks in Year I and 9 weeks in Year II participating in academics, while the remainder or majority of time is spent at specific locations engaged in supervised on-the-job training and project work. The composition of aca-

demic coursework is listed on Table VIII. Thus it it is apparent from the table that each university contributes approximately the same amount of sessions, yet these sessions are divided so that the best resources of each university are utilized.

Following completion of Part I of the examination and a program described above, the Trainee proceeds to "Higher Specialist" training. During this period of 3 years, he has an appointment equivalent to senior Registrar and serves in an area or district, or perhaps in an academic department or research unit. Project work would be completed during this time as required by Part II of the FCM exam. In addition, expertise with one of the sub-specialties would be developed (e.g. manpower, planning, epidemiology). Having completed Part II of the FCM exam, the Trainee would be eligible for full accredation as a Community Medicine Specialist.

SUMMARY

In summary, then, the data supports a view of the CMS in Wales as a Welsh middle-aged male with a public health background. The picture, too, is one of transition, as the CMS becomes acclimated to his new role in a vacuum of precedence. These roles are not only a result of the job description but also of the individual aspirations and biases of the CMS. Finally, both the long-term and the short-term education given these individuals would seem one way of modifying the self-image of the Specialty. It is these points that will be enlarged upon in the discussion to follow.

V. DISCUSSION

At the time of this study, the NHS was experiencing not only the upheaval of reorganization but also the effects of inflation. This took the form of multiple strikes and contract negotiations by dissatisfied working groups in the NHS. A newspaper clipping reprinted in Figure B gives some perspective to the problem and the possible issues facing medical administrators such as the CMS. Therefore, it could be argued that this was hardly an ideal time to study the NHS. However, regardless of the situation, certain consistencies emerged from the data; the turbulance of the time is taken into account in the discussion.

The data describe the CMS with respect to the three parameters of background, function, and education. If one looks at the literature relating to these aspects prior to reorganization, the overwhelming impression os one of blandness; of hope for this unprecedented approach to British health care, yet without a full knowledge of what form this creation would take. This blandness is most evident in the job descriptions for the various CMS; the official bulletins define the limits of function without describing the weighted importance. This type of definition was necessary due to the great unknown of the individuals who would fill the posts of CMS. Now, with most of the positions filled in Wales, a clearer picture of the CMS is emerging along with the direction he will pursue. Each of the three parameters above describes one aspect pf the CMS. Discussion will focus on each in turn in order to reach a composite picture of this group of individuals.

I. BACKGROUND -- CMS PROFILE

The data collected on the background of the CMS in Wales suggest a predominantly Welsh, middle-aged, male Specialist with a public health background. A consensus of those Specialists interviewed felt that age and professional background were important aspects in defining their outlook and approach to their function.

Age was important in two respects: (1) it defines, to a large extent, when these Specialists received their training and when they developed their professional views. The content and approach to the D.P.H. degree is likely to be different in 1974 than it was in 1950. (2) age usually defines the number of years the person has invested in the former NHS. Many of those interviewed indicated that the degree to which they would effectively reorient themselves to the new system would be influenced by their initial biases and how long these biases had operated in the NHS. The mean age of the AMO is the highest, and he has the most power in the present structure. The DCP, with his own but smaller domain, has the next highest mean age. The SCM, with the least amount of effective power in geographic domain, is the youngest group of Specialist in Wales. What is of particular interest is the large range of age for each group. It was acknowledged in some interviews that a 'generation gap' between the youngest and the oldest specialists is quite possible and should be avoided.

Professional background, defined as the principal post held prior to reorganization, assumes particular importance when the old structure

is replaced by one that bears little resemblance to it. There has been a philosophical and a practical reorganization in the NHS, leaving little vestige of traditional structure for the medical administrators. It is reasonable to assume that in the new structure, many of the Specialists will rely on their former expertise and way of handling problems until their new roles become more established. In particular, professional expertise plays an important role in the meshing of public health and hospital issues for the short-term.

The data show that the majority of all the Specialists in Wales come from the former public health sector. However, particularly for the AMOs, many Specialists had had experience in both public health and hospital sectors at one time in their career, and some maintained inter-sector contact by serving on various committees. All had the common basis of clinical training that was chiefly primary care oriented. Thus, many Specialists felt at ease in dealing with community health issues that crossed traditional boundaries. Those Specialists without much hospital experience indicated they would probably be less effective in their hospital decision-making until they had acquired more experience.

Those Specialists interviewed with appreciable hospital experience indicated a bias towards hospital-mediated community health services. Furthermore, placing hospital services as a high priority, they spent a good deal of time and effort with them. For example, one Specialist with a hospital background was interested in a data retrieval system for hospital records and establishing a traching hospital. On the

other hand, one Specialist with a public health bias indicated his interest in improving child health. All those interviewed agreed that having experience in both hospital and public health sectors was an advantage in establishing contact and maintaining communication with clinical colleagues. They also acknowledged that most of the problems requiring decisions by them in the early days of the new NHS revolved around hospital issues.

In areas such as Dyfed and Gwynedd where more Welsh is spoken, a Welsh background was considered preferable. Otherwise the only advantage a Welshman had over an Englishman is that he usually had a number of years to develop contacts and friends that were useful in his role transition.

The male domination of the Specialists may play no functional role; however, no women were formally interviewed. It is noteworthy, roughly 60% of the Trainees in the modular program are women, and application figures indicate that the ratio of men to women in the Specialty will change appreciably in the next few years in Wales. The effect of this cannot be foreseen.

The background and general profile of the CMS in Wales is far from complete. There were 7 vacancies in the SCM position and one in DCP at the time of the study. Many of the Specialists interviewed felt this was significant in two respects:

(1) The lack of SCMs hinders the efforts of the AMO. The SCM provides the AMO with much needed expertise in sub-specialty fields as statistics or planning, and

is thus a crucial part of the formulation of a cohesive policy for the area. Many of the AMOs did not have their full complement of SCMs. In particular, there appeared to be a dearth of qualified SCMs in Epidemiology and Statistics. This type of vacancy colored the AMO's fulfillment of his function, for he was forced to cover the vacant position himself. Most of the AMOs were attempting to devise interim arrangements for policy, and felt no firm picture of their planning effectiveness until after the appointment of sufficient SCMs.

(2) It was the consensus of the people interviewed that when these SCM posts ate filled, they will likely go to the present Trainees in the Specialty programs. Many of these Trainees are younger, women, and have no prior experience in the NHS to condition their attitudes. Thus it would appear that the profile of the CMS in Wales is still in a state of flux.

In summary, the CMS acknowledged that such factors such as age, professional and geographical background, and the presence of so many vacancies influenced their outlook and consequently their role in the new NHS. The composition of these factors is likely to change over the next five years, with the appointment of increasing numbers of younger people without allegiance to any of the former sectors.

II. FUNCTION

One of the most important and yet more difficult aspects of the

CMS to assess is his functional role. There is no precedence to the present NHS, so that the role specifications outlined in the various government bulletins gave little picture of what the self-concept of the CMS is, or what aspects of his functional role will occupy most of his efforts. We have already seen that individual biases in terms of background may play a part in how the CMS defines his priorities. Within this section, those priorities are set in motion and we examine the actual function of the CMS to see what his self-concept is and whether these values correspond to the way in which he is spending his time.

AMO

The data outlined in the AMO questionnaire demonstrate that the AMOs view themselves as health care planners, with their primary efforts spent working through their respective teams. In every category, value (self-concept) correlates with time spent on a particualr role.

First, some of the highest priorities of the AMO at the present time deal with establishing a data base of health information. This is one of the single most important aspects of their function in the early days of reorganization. Many AMOs feel they have to spend a considerable amount of time in building this data base; for others, the job is made easier by foreward-looking predecessors. But whether or not their situation dictates much time, the value ascribed to this part of their job is high. Virtually all the AMOs referred to the health information as the basis on which they would formulate and be questioned upon future policies. Projecting their future involve-

ment, most AMOs thought health information would retain a high level of importance to them as health planners, but would require less of their efforts as they delegated progressively more of it to SCMs.

Second, the values and the time ascribed to the planning function itself corroborate the AMO's image as primarily a health care planner. Interestingly enough, most of them acknowledged that it was impossible to think about planning or to spend much time with it now. As one AMO put it "We're just treading water now, getting used to it." Thus, the value and time ascribed to the planning function represents the impractibility of attempting to forge plans until the information about the needs becomes available, professional contacts become firmer, and staffing becomes complete. "There are simply more pressing things to do now while we settle in", said one. Therefore, the future value and time is really a better reflection of the AMO's self-concept. When asked what specific plans would receive priority, the response usually varied according to the area, but there was consistent emphasis on developing better facilities (two AMOs were interested in establishing teaching hospitals) and upgrading the services to special needs groups (chiefly the geriatric and mentally handicapped population).

Finally, the AMO as a planner placed emphasis on working through those groups or individuals involved in policy formulation: the AMT, the AHA and the DMT. The majority of the AMOs described their relationship to the AMT as the mot integral in developing plans for the area, and requiring the most time both now and in the future.

They described their relationship to the AHA as one of bearing respnsibility for the policies initiated as well as serving in an advisory role. The liaison with the DCP and the District Team is the way the AMO reviews the needs of the district and keeps informed on the implementation of plans. In the single-district areas, of course, there is no DCP or District Team, so that most of the effort is spent with the group of SCMs in deveoping policy. Again, most of the time is now spent in establishing professional rapport and handling intercurrent problems (e.g. industrial action by x-ray technicians) than in mapping out a cohesive policy. However, in the future, the AMOs feel these groups will be their primary point of reference as health care planners.

Other aspects of the AMO's function are those segments of management, advisory, and medical services roles he sees as requiring less of his efforts. Management of screening, health education, and social services each were given above average values but only average time. Much of this relates to the fact that these concerns can be carried on by other staff, and no time-consuming plans could be foreseen in the near future. Another managerial function often mentioned by the AMOs but not covered explicitly in their job description is the intangible task of establishing professional and public relations. The time spent on this aspect of administration depended on whether or not the AMO was well known in the area, but virtually all the AMOs conceded that their effective role and identity depended on medical and lay awareness of their capacity. Medical services were recognized

as more of a concern of the District Team; the type of service the AMO's staff would provide would be limited and advisory (e.g. an outbreak of salmonella in the area requiring notification of food handlers).

The advisory role of the AMO to bodies outside the NHS (social services, educational authorities, and voluntary bodies) was in stark contrast to those within the NHS (AMT, AHA) in that low ratings were given to those bodies outside the NHS. Some AMOs indicated crossing administrative boundaries made it more difficult. Others indicated little interest and expected little attention from these groups. One AMO likened it to the NHS before reorganization; legislated boundaries such that each sector had little interest with the other.

Single district areas deserve special mention. Gwynedd, South Glamorgen, and Powys are quite different from one another in demography and topography, but show certain similarities in the way the AMO functions. Since there is not DCP or DMT, considerable power and responsibility is concentrated in the hands of the AMO. In this setting, the AMO relies heavily on the SCMs as advisors in planning.

DCP

The data outlined in the DCP questionnaire also demonstrate that the DCPs see themselves as primarily health care planners, with their efforts channeled through the District Team and in tandem with the are staff (SCM or AMO).

Establishing and maintaining a health profile was seen as fundamental to any effort at planning by the DCP. As mentioned previously, this information was not well standardized when April 1 arrived, so that some DCPs found the job more time consuming than others. Some DCPs were engaged in this endeavor alone, while others had the assistance of area staff. Many of the DCPs indicated that the rapidity with which they completed the assembly of health information for planning purposes would depend on when the NHS became fully staffed. Thus, the role and status of health information is the same at the district level as it is at the area.

The actual policy formulation section of the questionnaire shows the same numerical trend for the DCP as for the AMO. That is, planning receives higher time and value in the future than now because of the process of settling into a new framework. Depending on their skepticism, too, some DCPs rated these functions lower now because they feel that the structure of the Welsh NHS strengthens the area planning initiative at the expense of the district. Therefore, much of their emphasis now related to whether they believed this situation would change over time and allow more local initiative in planning. Clearly, they preferred to participate in the planning process. Like the AMO, they would like special studies tp concentrate on the needs of the geriatric population, hospital demand, GP referrals, and patient movements. For now, some felt their primary activity would be implementation of policy conceived at a higher level. There is actually considerable importance in this fear of being pre-empted from active planning; if the DCP serves only to provide information

to the area and then to carry out and survey policy devised at the area level, it is likely that the popularity of the position will become diminished (both to the DCP and his clinical colleagues), and the efftiveness of a hospital-catchment basis blunted. For now there is fluidity in roles; it will take 3-5 years to see whether this fear is founded.

Corroborating the DCP image as a policy formulator is the weight given to preventive and child health in his management role, and the advisory effect he wishes to have upon his colleagues in clinical medicine. Many of the DCPs interviewed viewed prevetive medicine and child health not only as important holdovers from the old public health sector, but also as crucial avenues for community medicine reform to act. Reaching the younger children woth new programs of screening, they reasoned significant progress could be made in preventing chronic disease.

Responses to the DCP's present and potential role as an advisor to his clinical colleagues were mixed. Some felt encouraged about the communications that had occurred and foresaw greater reliance being placed on their interpretation of district policy. However, a significant number also voiced skepticism that this role would ever take up much of their efforts, or that the clinicians would seek them out in the future. An important component, said one DCP, would be to what extent the clinicians looked upon the CMS as an effective ally, and this in turn would depend on the DCP's and the district's power in initiating plans. In other words, if the clinicians considered the district segment of the NHS to be responsive to their needs, then the DCP's advisory role would increase. Hospital

consultants would be more affected by NHS policy, and it is reasonable that the DCPs view their relationship as stronger and more durable than with the GPs. The figures presented corroborate the interviews in that if further involvement with the clinicians occurs, it will probably center more around the hospital doctors.

Other functions of the DCP deserve brief mention. Medical services to Local Authority is mainly delegated to medical officers and does not occupy much of the DCP's efforts. One interesting fact was that most DCPs felt unduly burdened by occupational health, a holdover function from the public health sector. Many indicated they would prefer to delegate occupational health to a medical officer similar to environmental health. Consequently, this aspect of their job was the only one in which more time was spent than they valued. Social services, although recognized as important, received a similar response to that of the AMO. Finally Community Health Councils had not yet been formed at the time of the study, so their relationship to the DCP cannot be truly evaluated.

In summary, both AMOs and DCPs see themselves as health care policy formulators who rely heavily on firm data and channel their efforts through their respective management teams. The AMO retains more power and respoensibility for planning than the DCP; he may coordinated his efforts with the DCP, but ultimately an area plan must come from his office. The degree to which local initiative is preserved will depend on the responsiveness of the AMO. In single-district areas the AMO relies heavily on the SCM and spends more

time at the AMT in lieu of working with the DCP. The DCP, closer to the populace served, presently is more occupied with gathering information and performing surveillance on existing policy than engaging in much planning. In the future, however, he see his role evolving to a participant planner.

III. EDUCATION

Short-term: Reorientation

Short-term education for the CMS consisted of a series of reorientation courses offered in the two years preceding reorganization as outlined in the results of this study. During interviews, the opinions of the Specialists were solicited on reorientation --specifically what program of those listed they had attended, what they considered to be its strong points and weal points, and what type of ongoing reorientation they thought was suitable.

Of those AMOs and DCPs interviewed, most had a background from Wales and had attended the Weslh reorientation program. The result is that they had similar comments in assessing its efficacy in reorienting them.

Virtually all the responses demonstrated approval of the Welsh program. Many Specialists indicated that it had been supportive in the transition they had made from the old sector. The most positive reactions came from Specialists who gained better perspective of hospital management and coordinated health information systems. In

general, strong points of such a program for the Specialists were: (1) its early timing with respect to reorganization; (2) exposure to aspects of health care they had little experience with (e.g. planning) (3) exposure to academic literature and new concepts of management; (4) the common basis the experience gave them as a group.

Criticisms of the Welsh program were scattered. Some Specialists felt it was fragmented with too many disciplines involved; some felt the social services part was irrelevant to them, while others mentioned that much of the public health material (screening, child health) was redundant for them as public health officials. In retrospect, the majority of those interviewed suggested: (1) eliminating some of the breadth (e.g. social service) and concentrating more on depth with case studies in medical management and hospital planning; (2) having a couple of "refreasher" courses in the one and a half years that had elapsed between the initial course and reorganization. Most Specialists indicated they could have benefited more from such an approach because in the interval they had become more acquainted with aspects of community medicine they wished to discuss in more detail.

Most of the reaction about on-the-job reorientation focused on the need to meet with one another. Some of this is, in fact, taking place. AMOs meet regularly with SCMs and DCPs as a means of personal support and achieving professional goals. In addition, the Welsh Office arranges to have all-Wales meetings with the AMOs once a month. Here, besides appreciating the role of the Welsh Office in coordinating their interests, they have the opportunity to vent their frustrations

and questions with their new roles. The DCPs, however, have no such means of meeting and learning from one another. The majority interviewed wished to start all-DCP meetings at 6 month intervals. In addition, all the Specialists showed interest in the continuing education program offered by the London School of Hygiene, but admitted their duties would probably not allow them to attend in the near future.

Long-term: Training Programs

Long-term education remains the key as to how the CMS will evolve, for future graduates should have developed outlooks with minimal background bias. Since the formal training program organized by the Faculty is still in its infant stage with few participants, discussion of its potential effectiveness must be limited.

The Early Specialist training programs outlined before in the results occupied a major part of a symposium given by the FCM. Trainees from the London and modular programs shared their personal experiences for the first year. They each felt that the program they had participated had served their needs. Both emphasized that the teaching had been excellent, tutorial supervision good, and the problem-oriented approach well suited to their interests. The Trainee from the modular program made the criticism that there was a lack of definition in the reading and preparation for each module, and suggested that possibly a modular "script" be devised. In addition, he mentioned it was hard on some individuals in the modular program

to spend such a great deal of time away from home. Discussion of the modular program also touched on the point that of the original 7 Trainees, 2 had dropped out. Both the admission process and the structure of the course required further refining.

There are presently no Trainees in Higher Specialist training. However, most of the AMOs interviewed indicated that they would be interested in having such a Trainee to work with them. In fact, a couple of AMOs were drafting proposals for specifics posts. Usually, the type of post envisioned would be in the sub-specialties(SCM) at the area level. The obvious implication is the Trainee and the AHA would have the opportunity to look each other over for a permanent job. In this way, the staffing needs for qualified SCMs in the sub-specialties might be achieved sooner than the 6 years required for a full-fledged CMS. The pool of available Trainees in the Early Specialist phase is still small, and there is likely to be competition for their participation among the AHAs.

In summary, reorientation was a good attempt at short-term education, but it fell short of providing a continuum on which the Specialists could build. Long-term education provides a curriculum similar in longevity to clinical specialties with the goal of reaffirming consultant status for the CMS. Most of the CMS interviewed prefer the modular approach to Early Specialist training because it involves more field work. The graduates of these programs will form the pool of potential appointees for the vacant CMS positions.

Health Service on danger list

Western Mail Reporter

E NATIONAL Health Service ld be in ruins within weeks ause of spiralling industrial on by staff, say officials.

Radiographers at hospitals ughout Wales yesterday staged first of nine one-day bans on but emergency X-ray and radio- apy work.

On Monday morning manage- t engineers are threatening to off the power to hospital es and staff accommodation in h Wales in a bid to win recog- on for their union.

A spokesman for the South morgan Area Health Authority d yesterday, "The middle of t week will see the crunch. The le future of the health service t stake."

The Society of Radiographers, esenting skilled technicians who rate X-ray and radiotherapy pment, called on members to ve the emergencies-only ser- over a pay claim.

They are seeking a regraded structure with an interim award of 20 per cent while it is being worked out.

The radiographers will operate their ban on non-urgent work again on Tuesday, Wednesday and Thursday of next week and on one day of each of the five following weeks.

Spokesmen for the eight area hospital authorities in Wales said yesterday that the ban was bound to affect operating schedules already hit, in some cases, by other industrial action.

The South Glamorgan spokesman said that the ban would, in effect, halt non-emergency operations for more than a week.

The president of the society, Mr. John Watkin Evans, said in London yesterday that six students had left one school of radiography in South Wales to take up other jobs where they could earn far more than qualified radiographers.

Last-minute talks were going on over the weekend in an attempt to avert the engineers' action, which is the most serious threat to the health service so far.

About 90 engineers at hospitals in South and Mid-Glamorgan and Gwent, all members of the Electrical and Engineering Staffs Association, are seeking recognition as a negotiating body on the Whitley Council on health service pay to fight their claim for a new pay structure.

The regional organiser of EESA, Mr. Byron Thomas, said yesterday that the union had put their case to the Welsh Office, who will relay it to the Department of Health and Social Security. They were now waiting for a reply.

If their demand is not met the engineers will step up restrictions on the use of hospital laundries and cut all services, except cold water, to offices and staff living-quarters.

If these moves have no effect, they threaten to cut power supplies to selected hospitals.

A spokesman for the Gwent Area Health Authority said last night that the problems caused by a maintenance ban by hospital technicians had already forced them to cut back on non-emergency operations.

If the engineers went ahead with their threat to cut power supplies to selected hospitals "the repercussions would be tremendous."

He said, 'We are meeting the Welsh Office and reviewing the situation daily. We hope that things will not become desperate but we will have to be prepared for every eventuality."

THE SEVEN groups among Wales's 45,000 area health service employees taking industrial action are:

RADIOGRAPHERS, who are banning non-emergency work for nine days this month and next to back a claim for a 20 per cent. interim pay award while their salary scales are being reviewed.

ENGINEERS, who are threatening to cut off power supplies to hospital offices and staff quarters and even selected hospitals to back their claim for recognition of their union as a pay negotiating body.

NURSES, who are nominally continuing their ban on all non-nursing duties while awaiting the outcome of the special inquiry on their pay by Health Service Minister Mrs. Barbara Castle.

TECHNICIANS, who have banned non-emergency repairs and maintenance of hospital equipment made less than seven years ago — when they last had a wage review. They have now been recommended to accept a 20 per cent. interim pay award.

ADMINISTRATION and clerical staff, who are considering a ban on agency employment and other measures to protect their career structure.

DOCTORS, who plan to send a deputation to see the Prime Minister because they are dissatisfied with a seven per cent. pay offer.

BUILDING WORKERS in the health service are also in dispute and refusing to do work such as installing lifts and building new hospitals and nurses' accommodation.

VI. CONCLUSION

Reorganization and integration of the British National Health Service took place on April 1, 1974. Integration has consisted of a dtermined approach to shift the emphasis from the traditional disciplines of hospital, general practice, and public health to one centered around populations served. To this end, specific health boundaries were created and made coterminus with new government ones. In addition, a structure was created to decentralize authority from London and the DHSS to areas and districts involved. The Specialty of Community Medicine was created to transcend the old disciplines and to administer to population-oriented health care.

In Wales, Community Medicine Specialists exist a three main levels in medical administration: the Area Medical Officer, the Area Specialist in Community Medicine, and the District Community Physician. These individuals were the center of a study that focused on their background, function and education.. A working premise was that their educational preparation and professional background might affect their functional role.

The profile of the CMS in Wales showed a number of vacancies at the SCM level. In addition, background information on the CMS showed a predominantly male, middle-aged group of public health trained individuals. Of the three levels of Specialists, the AMO position has the most power, the highest mean age, and the highest proportion of hospital-trained personnel. This may reflect a tendency to get individuals with the broadest and largest amount of

experience in the positions of power in the NHS. AMOs and DCPs interviewed acknowledged that their background and age affected their approach to their job. The composition of the background factors is likely to change over the next five years with the appointment of increasing numbers of younger Specialists without allegiance to any of the former sectors.

The job description forms the basis for the function of the CMS, but his background, attitudes, and self-image come to bear on its fulfillment. The AMO and DCP both consider themselves health care planners, formulating policy to serve the needs of their populations. Most of the proposed policies demonstrate an emphasis on improving medical care in a public health oriented fashion, with mentally handicapped, geriatric and children receiving special attention in future programs. To this end, the AMO and the DCP place a high reliance on a firm data base, and are spending considerable time building such a health profile. Thier primary frame of reference for accomplishing these tasks are their respective teams. Presently, they are hindered by lack of qualified staff, and spend much of their time at tasks they would ordinarily delegate to others. In the future, they both expect their role to be participant planners. The degree to which the DCP will achieve this status will depend on how much local initiative he is allowed.

All the CMS participated in reorientation programs for their present jobs. They felt the programs had been beneficial, but would have preferred more continuity between the initial courses and the

April 1 deadline for the new NHS. They considered reorientation courses less instrumental than their own background in forming their attitudes. They recognized the need for continued peer group communication and continuing education. The Faculty has outlined its proposals for a training scheme leading to a CMS of consultant status. The program is designed to provide multidisciplinary training and presently has a small number of Trainees participating in it. These Trainees will form the available pool for the future CMS positions.

A number of issues have surfaced in the course of this study, and require further investigation. First and foremost is the struggle for a working definition of community medicine. There are definitions to be sure. But the important issue is whether these definitions can be translated into practical health care delivery. Second, we have seen that personal attitudes and power structures both contribute to the way in which the CMS carves out a role for himself. Finally, a real question which only time can answer, is the CMS really only "old wine in new bottles"?

FOOTNOTES

1. Chester and Battistella, "British NHS Reorganisation: Aims and Issues" NEJM 289:10-5, Sept 1973. also ref to the NHS Reorganisation Act 1973.

2. Royal Committee Report on National Health Insurance, Cmd 2596 HMSO 1926.

3. Report of the Medical Planning Committee of the BMA in BMJ 1:743 (1942)

4. Beveridge, Sir W., "Social Insurance and Allied Services", Cmd 6404 HMSO 1943.

5. In Murray Why a National Health Service, Pemberton, 1971, p. 55.

6. Eckstein, The English Health Service, Oxford Univ. Press, p. 148.

7. Brotherston, "Reorganizing the British NHS" Yale J. of B&Med, 46:125, (1973).

8. Green Paper on NHS Reorganisation, HMSO, 1970.

9. Consultative Document on NHS Reorganisation, HMSO, 1971, p. 3.

10. Office of Health Economics, NHS Reorganisation, (1974) p. 10.

11. Ibid., p. 11.

12. Brotherston, p. 126.

13. Office of Health Economics, p. 8.

14. Ibid., p. 15.

15. "Mangement Arrangemants for the Reorganised NHS in Wales (Red Book) HMSO (1972) pp. 36-7.

16. Faculty of Community Medicine, "Standing Orders" (1972) p. o.

17. Ibid., p. 0.

18. Ibid., p. 1.

19. Ibid., p. 1.

20. Ibid., p. 1.

21. Hunter Report, HMSO (1972), p. 26.

22. Ibid., p. 27.

23. Silver, "The Community Medicine Specialist" NEJM 287:1299-1302 (1972), p. 1299.

24. Welsh School of Medicine, "A Course for Medical Administrators" Cardiff, 1972, p. 1.

25. FCM, White Paper (unpublished 1974), p. 1.

TABLE I.

STRUCTURE OF THE NHS ---- 1948- 1974

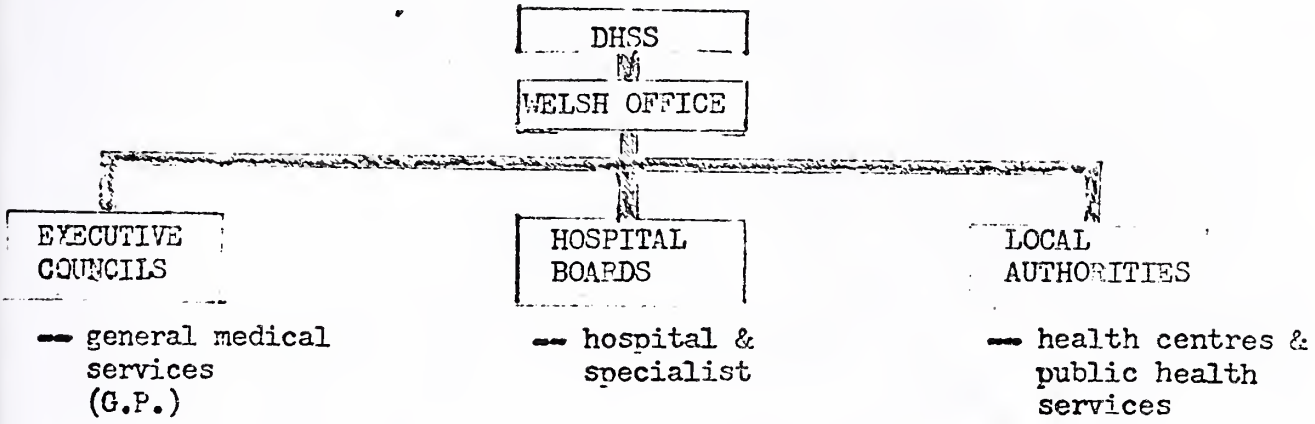


TABLE II.

STRUCTURE OF THE NHS ****** 1974-

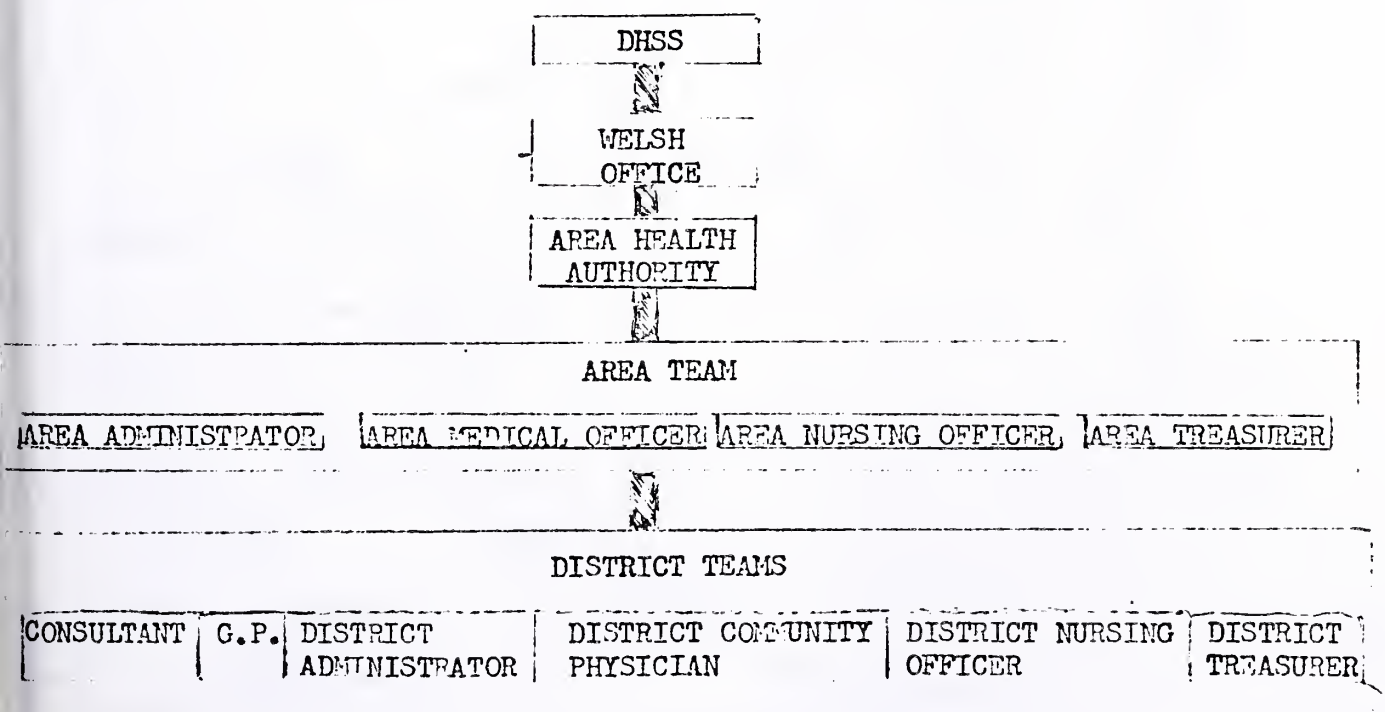
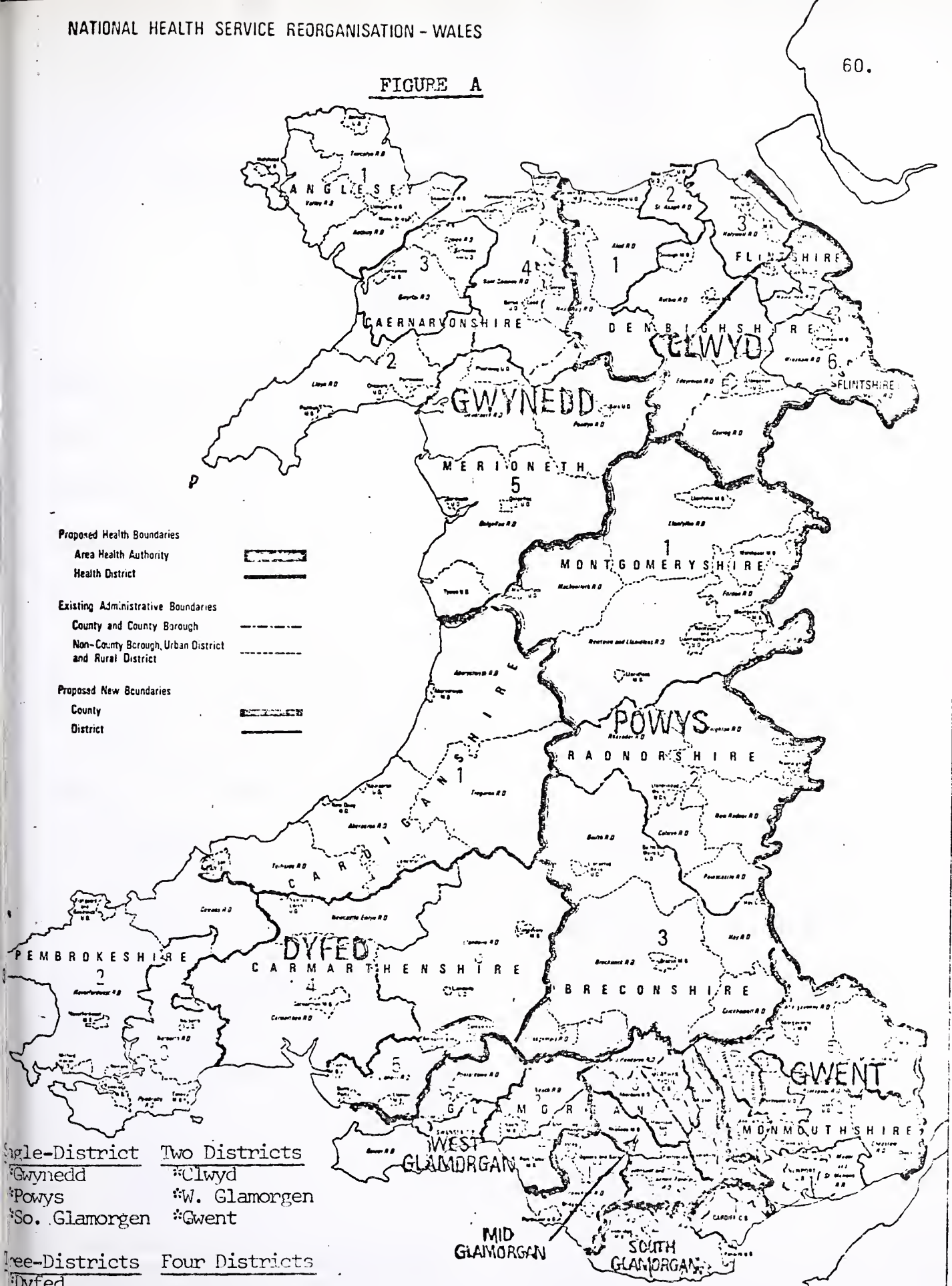


FIGURE A



Single-District	Two Districts
*Gwynedd	*Clwyd
*Powys	*W. Glamorgen
*So. Glamorgen	*Gwent

Three-Districts	Four Districts
*Dyfed	*Mid-Glamorgen

SOURCE: Welsh Office

TABLE III

PROFILE OF THE CMS IN THE WELSH NATIONAL HEALTH SERVICE

	POSTS		
	AREA MEDICAL OFFICER	DISTRICT COMMUNITY PHYSICIAN	SPECIALIST IN COMMUNITY MEDICINE
Number of Positions	8	14	18
Number of Appointments	8	13	11
Appointments in 1973	7	11	4
Appointments in 1974	1	2	7
Sex:			
Male	8	13	9
Female	0	0	2
Age:			
Average	49	48	45
Range	36 - 51	37 - 59	34 - 54
Year of Qualification:			
MB*			
Average	'50	'51	'53
Range	'41 - '60	'36 - '60	'44 - '62
DPH**			
Average	'56	'60	'59
Range	'47 - '64	'39 - '69	'50 - '70
Principle Post Prior to Reorganization:			
Professional			
Public Health	6	11	9
Hospital	2	1	1
Other	0	1	1
Geographical			
Wales	6	12	10
England	2	1	0
Other	0	0	1

*MB: equivalent to American M.D.
**DPH: equivalent to American M.P.H.

TABLE IV

CLASSIFICATION OF FUNCTION OF SPECIALIST IN COMMUNITY MEDICINE

AREA LEVEL - AMO*

	AT PRESENT		2 YEARS HENCE	
	Time+	Value	Time+	Value
Provision and/or Interpretation of Health Information				
(a) Epidemiology	2.3	2.0	2.6	1.3
(b) Manpower	1.9	1.4	3.1	1.5
(c) Services	1.7	1.4	2.8	1.8
(d) Other				
Policy Formulation and Planning				
(a) Operations Research	3.8	2.2	1.8	1.5
(b) Health Care Policies	2.8	2.2	1.2	1.1
(c) Other	2.5	2.5	1.5	1.5
Management---Coordination and Monitoring of and Liaison of Services				
(a) District Team Performance	2.6	2.0	2.6	1.8
(b) Screening/Health Education	3.4	2.6	3.0	2.0
(c) Special Needs Groups (eg. geriatrics)	2.3	2.1	2.1	1.7
(d) Social Services	4.3	2.6	3.2	2.4
(e) Other (Professional Relations)	2.3	2.3	3.0	2.0
Provision of Medical Services to Local Authority				
(a) Through District Management Team	3.4	2.4	3.8	2.4
(b) Through Own Staff	3.5	2.6	4.0	3.5
(c) Other	2.6	2.6		
Advisory as Specialist to				
(a) Social Services Department	4.5	3.0	3.8	2.6
(b) Education Authority	4.5	3.0	3.6	3.6
(c) AHA	1.5	1.1	1.2	1.0
(d) Voluntary Public Bodies	4.8	4.0	4.4	3.6
(e) Area Management Team	1.0	1.0	1.1	1.0
(f) Other				

*All figures presented in this table are averages.

+Amount of Time Spent

TABLE V

CLASSIFICATION OF FUNCTION OF SPECIALISTS IN COMMUNITY MEDICINE

DISTRICT LEVEL - DCP*

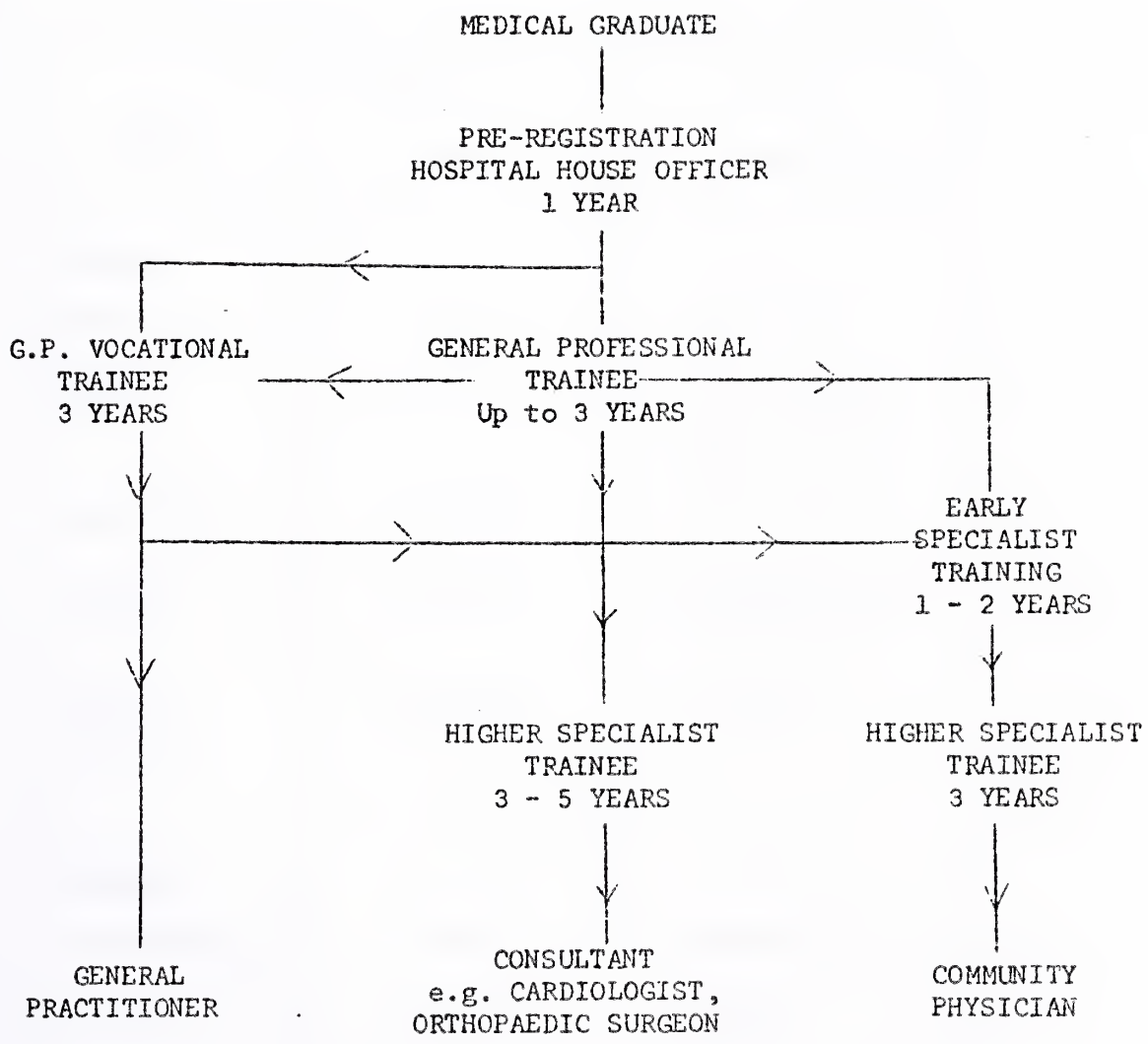
	AT PRESENT		2 YEARS HENCE	
	Time+	Value	Time+	Value
Provision and/or Interpretation of Health Information				
(a) Environmental Health	4.2	3.9	4.2	3.3
(b) Maintaining Health Profile	2.0	1.3	2.6	1.3
(c) Other				
Policy Formulation and Planning				
(a) With District Management Team	2.3	1.5	1.2	1.2
(b) Special Studies	2.4	1.8	1.8	1.4
(c) Other				
Management---Coordination of and Liaison with Services				
(a) Preventive (eg. immunisation)	3.2	1.9	2.1	1.8
(b) Child and School Health	2.3	2.1	2.5	2.0
(c) Social Services	3.3	2.9	3.6	2.9
(d) Other (Professional Relations)				
Provision of Medical Services to Local Authority				
(a) Environmental Health	4.0	3.6	3.8	3.4
(b) Communicable Disease Control	3.6	2.4	3.6	2.5
(c) Other (Occupational Health)	2.9	3.7	3.5	3.7
Advisory as Specialist to				
(a) Clinicians				
(1) G.P.	3.7	2.2	3.7	2.9
(2) Hospital Specialists	3.0	2.1	2.9	2.2
(b) Community Health Council	---	---	3.7	3.1
(c) Other (Nursing, Voluntary Bodies)				

*All figures presented in this table are averages.

+Amount of Time Spent

TABLE VI.

SPECIALIST TRAINING



Source : FCM

Note - Stage 2 General Professional Training

Stage 3 Early Specialist Training (Up to at least Part I of the M.F.C.M.)

Stage 4 Higher Specialist Training (Completion of M.F.C.M. and further experience)

Stage 5 Accreditation (Joint Committee for Higher Medical Training).

TABLE VII

TIMETABLE

Region	Duration of course	Time suggested
Year 1		
Bristol	3 weeks	1-19 October
Wales	2 weeks	3-14 December (provisional)
Birmingham	2 weeks	4-15 February
Oxford	2 weeks	26 March-5 April (provisional)
Bristol (Exeter)	2 weeks	20-31 May
Year 2		
Southampton	3 weeks	September/October
Oxford	2 weeks	December
Wales	2 weeks	March
Birmingham	2 weeks	May/June

SOURCE: MODULAR TRAINING PROGRAM BROCHURE.

TABLE VIII

	1 Bristol	2 Wales	3 Birmingham	4 Oxford	5 Bristol (Exeter)	6 Southampton	7 Oxford	8 Wales	9 Birmingham
Epidemiological and Statistical Methods		10	4	4	3	6	4	5	4
Epidemiology (non-com.)		4		2		5	3	2	
Epidemiology (com.)	6				4				
Environment	10								
Occupational Health		4						4	
Medical Sociology) Social Administration)	8					4	4		
Medical Care	4	2	6	4		8	6	4	6
Operations research				10	3	4			
Information					10	3	3		2
Management	2		10					5	8
TOTAL	30	20	20	20	20	30	20	20	20

APPENDIX B.

Within the georgaphic paramters of the Welsh NHS, factors such as population density and distribution, socioeconomic background and occupation, general standards of health and hygiene will be important indicators to the CMS of how to plan for the needs of his area. Likewise, resources in the form of medical manpower and facilities will be important in determining whether these needs can be met. To gain perspective of the issues facing the CMS in Wales, a short "profile" of these factors will be presented.

Table IX shows the distribution of population and area in the AHAs in Wales. Infant mortality is included as a rough estimate of the living conditions (hygiene) and general health of the population. These figures reveal most of the Welsh population concentrated in the industrial north and south coasts (Clwyd, Gwent, and the Glamorgens) with the corresponding industrial needs of health care. The other areas (Dyfed, Gwynedd, and Powys) are more sparsely populated with predominantly agrarian inhabitants. Gwynedd amd Dyfed are also the resort areas of Wales, and experience cyclical shifts in population and health care demand. Looking at infant mortality, what stands out is that an AHA such as Mid-Glamorgen heavily endowed with industry and medical manpower/facilities, has a larger rate than Gwynedd with fewer medical resources. Thus, for example, if the CMS in the Mid-Glamorgen area were concerned with this rate, he might seek out possible causes and then try to correct these by planning more resources around (for example) perinatal hygiene.

Questions of medical manpower will face the CMS. For instance, the CMS might determine that the population of mentally handicapped people in his area requires additional nursing care homes or doctors; or perhaps a rural area is covered by too few physicians. It will be up to the CMS to assess these needs and formulate plans to meet them. In general the distribution of medical manpower follows that of population distribution. Nursing staff, GPs, and public health staff are distributed approximately evenly among the AHAs as shown on Table X. Mid-Glamorgen has the highest number of the above staff, while Gwynedd and Powys, have the lowest. The distribution of hospital doctors (consultant and non-consultant), however, heavily favors South Glamorgen. South Glamorgen is the seat of the capital of Wales and the Welsh National School of Medicine, so it has been assigned the status of "Teaching" AHA. It should be noted, therefore, that the medical facilities and manpower (e.g. consultants) reflects the teaching status and poses additional issues for the CMS to face. The consultant figures only reflect the working hours and not the place of residence or major area of work. Thus, for instance, there is considerable flow of doctors from South and West Glamorgen to Powys and Dyfed respectively. The Glamorgens and Gwent account for a higher proportion of hospital doctors than figures show. One of the questions facing the CMS might be ways of attracting more hospital doctors to an area such as Gwynedd.

Medical facilities, as measured by different categories of hospital beds, is one of the major resources and financial concerns with which the CMS must deal. The breakdown of beds in Wales given on Table XI illustrates the type of facilities and their distribution.

The figures respresent the facilities that must be maintained as well as serving as the total supply of hospital beds to meet the medical demands of each population.....for this reason, the beds are listed according to population they serve. The figures show that the Glamorgens and Gwent have the largest amount of acute beds, while Dyfed appears to show a high proportion of mental illness beds.

Hospital admissions reflects utilization of (mainly acute) medical facilities by an area's population. There is considerable overlap of health services when patients in some areas travel to others for care. Table IX illustrates this point by comparing the flow of patients across the AHA boundaries. In an area such as Powys, with few medical facilities or personnel, 67% of the population admitted to hospital travel outside the AHA for treatment. Even in areas with adequate facilities and bordering on England (Clwyd and Gwent) there is still a significant percentage travelling to England for care. Population shifts such as this may affect the priorities of the CMS in planning for future hospital services in his locale.

In summary, each of the AHAs in Wales will be competing for medical resources, and the profiles given will be one of the ways the CMS assesses the needs of his area. Population, medical facilities and manpower, and utilization of facilities will be important parameters by which each CMS must contend.

TABLE IX.

AREA HEALTH AUTHORITIES

POPULATION, AREA AND INFANT MORTALITY

AREA HEALTH.	POPULATION(+)	AREA (*)	INFANT MORTALITY++
CLWYD	358,000	937 sq,m.	16.7/1,000
DYFED	314,000	2226 sq m.	14.3/1,000
GWENT	440,000	531 sq.m.	16.5/1,000
GWYNEDD	220,000	1493 sq.m.	16.4/1,000
MID-GLAM.	531,000	393 sq.m.	18.5/1,000
POWYS	99,000	1960 sq.m.	15.5/1,000
SO. GLAM.	390,000	161 sq.m.	16.4/1,000
WEST GLAM.	372,000	315 sq.m.	14.7/1,000

+ = Source 1971 Census

* = Source Demography Section, Welsh Office

++= Source Welsh Office -includes mortality up to one year of age and excludes stillbirths.

TABLE X_a.

The approximate number of nursing staff in post in each Area Health Authority in Wales at the time of the National Health Service reorganisation (1 April 1974) are as follows:-

Gwent	2934
West Glamorgan	2143
Dyfed	1980
Mid Glamorgan	3916
Gwynedd	1542
South Glamorgan	3907
Clwyd	2443
Powys	838

The figures include nurses in hospital and the community services. All grades are included, administrative, tutorial, all qualified staff, learners and untrained staff.

1 August 1974

TABLE X_b.

As at 30 September 1973.
St aff In Post

HOSPITAL MEDICAL STAFF
(WTE)**

	Consultants (WTE)	SHMO with allow.	SHMO without allow.	Med. Asst.	Sen.Reg.	Registrar	SHO	House Officers (Pre & (Post Reg)	TOTAL NON-CONSUI STAFF
Clwyd	68.33	-	2.27	13.08	6.0	28	46	12	107.35
Dyfed	60.61	-	0.18	11.91	1.94	22	35	4	75.03
Gwent	73.72	-	1.18	10.09	9.91	29	66	13	129.18
Gwynedd	32.28	-	1.36	4.55	1.0	11	21	7	45.91
Mid Glam	78.25	2	2.73	16.82	2.0	40	58	9	130.55
South Glam	141.51	-	1.36	9.51	57.0	96	100	44	307.37
West Glam	73.55	1	-	11.00	10.0	33.5	48	20	123.5
Powys	6.50	-	1.91	2.00	-	2.00	1	-	6.91
ALL WALES	534.75	3	10.99	78.96	87.85	261.5	375	109	926.3

1.0 WTE = 11 ½-day session

** = WTE is Whole Time Equivalent and stands for 11 one half day sessions held by Consultants per week. Thus, instead of absolute number of consultants, these figures respresent the number of "functional" consultants.

SOURCE: WELSH OFFICE

TABLE X_b (CONTINUED)

	General Practitioners	Community Medicine (Administrative and (Non-administrative (Medical Staff)
Clwyd	155	30
Dyfed	163	26
Gwent	199	37
Gwynedd	118	32
Mid Glam	226	68
South Glam	188	24
West Glam	163	39
Powys	62	13
ALL WALES	1274	269

TABLE XI.

AHA / TYPES OF BEDS	MA	PG	MI	ML	MS
CLWYD	1600	300	780	483	150
DYFED	850 *	573*	922	68	60
GWENT	1695	44*	1502*	304	524
GWYNEDD	503	77		386	462
MID-GLAM.	2,005	218	1652	413	601
POWYS	233	55	450	399	105
SO. GLAM.	1794	929	729	270	610
W. GLAM.	1558	425	675	158	91

KEY:
MA = Mainly ACUTE
PG = Psychogeriatric
MI = Mental Illness
ML = Mainly Longstay
MS = Mental Subnormality

Source: Welsh Office Statistics
numbers with (*) may be incorrect due to differences in definition.

TABLE XII

"General" Hospital Patient Flows

Areas and Districts	Population (000's)	Percentage of Patients going as inpatients to "General" Hospitals			
		Within District %	Other Districts within AHA %	Other AHAs in Wales %	England
CLWYD	358				
Wrexham	204	70·0	3·5	0·5	26·0
Rhyl	154	81·0	3·5	1·5	14·0
GWYNEDD	220	77·0	—	11·0	12·0
POWYS	99	33·0	—	31·0	36·0
DYFED	314				
Aberystwyth	55	60·5	24·5	13·0	2·0
Haverfordwest	97	59·0	31·5	8·5	1·0
Llanelli	93	40·0	15·5	43·0	1·5
Carmarthen	69	70·0	7·0	19·5	3·5
WEST GLAMORGAN	372				
Swansea	245	94·5	1·0	3·5	1·0
Neath	127	86·0	9·0	4·0	1·0
MID GLAMORGAN	531				
Bridgend	124	86·0	4·0	9·5	0·5
East Glamorgan	175	89·5	0·5	9·5	0·5
Merthyr	133	77·5	9·5	12·0	1·0
Caerphilly, Gelligaer, etc.	99	53·5	8·0	38·0	0·5
SOUTH GLAMORGAN	390	94·5	—	4·5	1·0
GWENT	440				
Newport	322	82·0	5·0	10·5	2·5
Abergavenny	118	63·0	23·5	12·0	2·0

Notes:

1. Figures are based on a special analysis of the places of residence of inpatients treated in "general" hospitals in Wales in 1970, and in "general" hospitals in England for the same period, i.e. the table *excludes* patients treated in mental illness and mental handicap hospitals.

2. The table shows e.g. that of the residents of the Aberystwyth District who were given treatment in a "general" hospital, 60·5% received it in the District, 24·5% received it in other Districts of the same AHA. 13% received it in other AHAs in Wales and 2% received it in England. For Gwynedd, Powys and South Glamorgan it shows similarly the proportions treated within the AHA, other Welsh AHA's and in England.

3. The population figures in the first column are taken from the 1971 Census. They are for permanent residents, and do not, for example, take account of summer visitors.

SOURCE: RED BOOK ON WELSH REORGANIZATION.

BIBLIOGRAPHY

I. COMMUNITY MEDICINE IN BRITAIN

Brotherston, J. "The Future of the Public Health Doctor" Public Health 84:57-9, Jan 1970.

Carrick T, "Teaching of Community Medicine. The Army Point of View" Community Health (Bristol) 4:285-7, March 1973.

Cochrane, A.L., Effectiveness and Efficiency, Nuffield Press, 1972.

"Community Medicine--Impressions of Cogwheel: The MOH", BMJ 4:166-7, '72.

"Community Medicine", BMJ 2:417-8, May 1971.

"Community Medicine", Health Visit 44:367, Nov. 1971.

Ebie, J., "An Integrated Approach to Community Health" Health Bull. (Edin) 28:168-75, May 1970.

Elliott, R., "The Future of the Public Health Doctor", Public Health 84:59-66, Jan 1970.

Gibson, R., "Organization and Management of Health Services" BMJ 1:353-6, May 1970.

Hannay, D., "The Population as Patient" BMJ 5:220-5 Sept 1971.

Kennedy, W., "Aspects of Community Care" Nursing Times 69:517-8, APr. 1973.

Kirk, C., "NHS: Management and Community Participation" Lancet 1: 1006-7, May 1972.

Lindon, R., "The Future of the Public Health Doctor" Public Health 84:71-94, Jan 1970.

Macara, A., "The Teaching Of Community Medicine To Undergraduates" Comm. Health (Bristol) 4:278-82, March 1973.

McGuire, B., "Health Centre Practice and Area Study", Queens Nursing J 16:58-9, June 1973.

McKeown, T. and Lowe, C.R., Social Medicine, London: Blackwell, 1974.

McMullen, J., "Care in the Community", Proc.Roy Soc Med. 66:139-41, Feb'73.

Millar,D., "Health Centres and Excellent Medicine" JRColl GP 22:866-74, Dec 1972

Nelson, R., "Common Ground" Lancet 2: 139-41, Jul 1973.

Parry, W.,"Community Medicine" Comm. Health (Bristol) 4:23-7, Aug '72

Pemberton, J., "Practical Work in Epidemiology and Community Medicine", Int.J.Epid. 2:399-405, Winter 1973.

Preston, J., "The Future of the Public Health Doctor" Public Health 84:66-71, Jan 1970.

Reynolds, G., "The Future of Community Medicine" BMJ 4:670-3, Dec 1971.

Roberts, G., "The Future of Community Medicine" BMJ 1:247 Jan 1972.

Simpson, A., "Community Medicine" BMJ 2:230 Apr 1972.

Swatfield, J.,"The MOH and Local Government" Public Health 83:293-305 Sept'69.

Vickery, K.,"The MOH and Other Services" Comm Health(Bristol)4:34-7,Jul'72.

Warren, M., "The Concept of Community Medicine" Comm Health (Bristol) 4:275-8, Mar 1973.

Warren, M. and Acheson, R., "Training in Community Medicine and Epidemiology in Britain" Int.J.Epid.,2:371-8, Winter 1973.

"Who's for Community Medicine?" Lancet 2:1297-8, Dec 1972.

II.REORGANIZATION OF THE BRITISH NHS

Battistella R., and Chester T., "The Reorganization of the BNHS -- Aims and Issues" NEJM 289: 610-5, Sept. 1973.

Battistella R., and Chester T., "Reorganization of the NHS: Background and Issues in England's Quest for Comprehensive-integrated Planning and Delivery System" Millbank Mem Fund Q 51:489-530 ,1970.

Birley, J., "Reorganisation of the NHS" Lancet:2:817, Oct 1972.

Brotherston, J., "Reorganization of the British NHS--1972" Yale J of Bio and Med, 46:125-133, 1973.

Carne, S., "The Hunter Report -- A GP's Point of View" , RSHJ 1:42-4, Feb '73.

"Community Health Councils" Lancet 1: 357-8, Feb 1973.

Cook, D., "The Reorganisation of the NHS. The Viewpoint of the GP" Roy SocHJ 92:28-32, Jan 1972.

Cooper M, and Culyer A., "An Economic Survey of the Nature and Intent Of the British NHS" Soc Sci and Med, 1971.

Cooper, P., "What Will Reorganisation do for the Patient?" Lancet 1:670-1 Apr 1974.

Dansie, C., "Faculty of Community Medicine", Lancet 2:979, Oct 1971.

DHSS, " National Health Service Reorganisation in Wales" (White Paper) CMND 5057, Cardiff HMSO 1972.

DHSS, "Democracy in the NHS", HMSO, 1974.

DHSS, Cymru: Wales, Cmd 4988, HMSO, 1971.

Drain, G., "The Reorganisation of the NHS: The Viewpoint of the Local Authority-" Roy. Soc. HJ 92:16-19, Jan 1972.

Draper, P., "The NHS. Three Views" Fabian Res. Series, 287. 1970.

Eckstein, H., The English Health Service, London: Oxford Univ. Press (1959)

"Editorial: Progress Report on Reorganisation", Lancet 2:1370, Dec 1973.

Forsyth,G., Doctors and State Medicine, London: Pittman, 1973.

Fowler, F., "The Reorganisation of the NHS. The View-point of the Hospital Service" Roy Soc HJ 92:24-8, Jan 1972.

Freeman, H., "Reorganisation and the NHS" Lancet 1:422-3, Feb. 1973.

Galloway, T., "The Hunter Report -- A M.O,H.'s Point of View" Roy Sco HJ 1:44-5, Feb 1973.

Hardiman, P.,"Reorganisation of the NHS in Wales" Lancet 2:1371. Dec 1972.

Hasslewood, G., "Reorganisation of the NHS" Lancet 2:763, Oct 1972.

Health, P., "The Medical Administrators in the NHS" Comm. Health (Bristol) 2:178-82, Jan 1974.

Heycock, J., "Some Thoughts on the Future of the NHS", Comm. Health (Bristol) 2:143-7 Nov. 1970.

Kirwan, J., "NHS Reorganisation: The Politics of Second Best" Lancet 2:418-20, Aug 1972.

Lister, J., "NHS--A Clinician's View" NEJM 289:636-7 Sept 1973.

Lycett, C., "The Reorganisation of the NHS. The Viewpoint of the Public Health Officer" RSHJ 92:20-3, Jan 1972.

Maxwell, R.,"Management for Health" BMJ 1:160-4, Jan 1973.

Murray, D. Stark., Why a National Health Service? London: Pemberton 1971.

--------, Blue print for Health, London: Allen and Unwin, 1973.

"NHS Reorganisation Bill" Lancet 1:1522-3, June 1973.

Noyce, J., "Regional Variations in Allocating Financial Resources to Community Health Services" Lancet 1:554-7, Mar 1974.

Office of Health Economics, The NHS Reorganisation, London 1974.

Ratoff, L., "Seebohm and the NHS" BMJ 2(supp) 51-3, May 1973.

Reorganisation 1974 or 1984? The Area Joint Liaison Committee and the Area Profile" BMJ 2: 542-3 June 1973.

Reorganisation 1974 or 1984? Three Doctors' Dilemmas, BMJ 2:478-9, May 1973.

Reorganisation of the NHS in Wales, BMJ 4:61, Oct 1972.

Robson, J., "Reorganisation of the NHS" Lancet 2:648-9, Sept 1972.

Scottish Home and Health Dept., "Doctors in an Integrated Health Service", HMSO 1971.

Smith, E., The Reorganisation of the NHS. An Outline and General Proposals" Roy Soc MJ 92:12-5, Jan 1972.

Stallworthy, J., "New Wine in Old Bottles --Team Concepts and Community Medicine" Proc Roy Sci Med 63:491-5, May 1970.

Stewart, T., "The Reorganisation of the NHS. The Viewpoint of the Patient" Roy Soc MJ 92:32-4, Jan 1972.

Tate, G., "Health Centre Practice" JR. Coll. GP 21:336-45, Jan 1971.

West, R., "Letter: Reorganisation of the NHS Number" BMJ 4:674, Dec 1973.

Whelan, N., "Reorganisation of the NHS", Lancet 2:1452, Dec 1973.

III. THE COMMUNITY MEDICINE SPECIALIST

Battistella, R., "The Role of Management in Health Services in Britain and the U.S." Lancet 1:626-30, Mar 1972.

Brotherston, J., "The Specialty of Community Medicine" Roy Soc MJ 4:203-5, Aug 1973.

Bryden, J., "The Relation of the Specialist in Community Medicine to the GP" Health Bull, 30:51-2, Jan 1972.

Dixon, P., "Teaching Community Medicine" Comm. Health (Bristol) 4:282-4, Mar 1973.

DHSS, Management Arrangements for the Reorganised NHS (Grey Book) HMSO 1972.

DHSS, Memoranda Concerning Welsh Reorganisation 1973-74, Welsh Office.

DHSS, Working Party on Medical Administrators (Hunter Report) HMSO 1972.

"Editorial: The Future of the Community Physician" Lancet 1:547-8, Mar 1974.

Faculty of Community Medicine, "Standing Orders" Harrison, 1972.

Ferrer, H., "The Community Physician --Monitor or Minotaur" Public Health 85:280-5, Sept 1971.

Garraway, M.,"Clinician and Community Physician in an Integrated Health Service" Lancet 2: 129-30, Jul. 1972.

Gilloran, S., "The Relationship of the Specialist in Community Medicine to Environmental Health Services" Health Bull. 30:67-8, Jan 1972.

Harding, W., "The Alliance in Community Medicine" Public Health 86:325-38, Sept 1972.

Kirk, J., "The Relationship of the Specialist in Community Health to the Clinical Organization" Health Bull. 30:48-50, Jan 1972.

Lister, J., "Any Complaints? The Community Physician" NEJM 286:1144-6

Ludkin, S., "Community Health Services 1974 -- Anew Structure" Roy Soc HJ 93:46-7 Feb 1973.

McNeil, N., "Manpower Needs in the Specialty of Community Medicine" Health Bull. (Edin) 30:53-62, Jan. 1972.

Mechanic, D., "General Medical Practice :Some Comparisons Between the Work of Primary Care Physicians in the U.S. and England/Wales." Medical Care 10:402-20, Sept 1972.

Morris, J., "Tomorrow's Community Physician", Lancet 2:812-6, Oct 1969.

Murchison, M., "The work of the Specialist in Community Health" Health Bull. 30:43-7. Jan 1972.

Nelson, R., "Observations on Administrative Reorganisation and Post-Graduate Medical Education" Johns Hopkins MEd J 134:191-200. 1974

Parry, W., "The Community Physician of the Future" Roy Soc HJ 91:33-5, 1971

Reid, J., "The Community Medicine Specialist" Pub Health 86: 286-92. '72.

Scottish Home and Health Dept., Community Medicine in Scotland HMSO, 1973.

Silver, G., "The Community Medicine Specialist" NEJM 287:1299-1301 Dec. 1972.

Stewart, G., "Community Medicine --The Symbol of Integration" Roy Soc HJ 4:205-7, Aug 1973.

Vickery, K., "Community Physician. A Statutory Consult" BMJ 1:805 Mar 1973.

Warren, M., "The NHS and the Planning of GP Services in England and Wales", Acta Soc Med Scand, 3:1-16, 1971.

Welsh Office, Management Arrangements for the Reorganisation of the NHS in Wales. (Red Book), Cardiff, HMSO 1972.

Whitty, C.,"Management and Community Participation" Lancet 1:1121. '72.

Willey, R., "Community Officer --Linking Home and Hospital" Nursing Times 68:547-8, May 1971.

YALE MEDICAL LIBRARY

Manuscript Theses

Unpublished theses submitted for the Master's and Doctor's degrees and deposited in the Yale Medical Library are to be used only with due regard to the rights of the authors. Bibliographical references may be noted, but passages must not be copied without permission of the authors, and without proper credit being given in subsequent written or published work.

This thesis by has been used by the following persons, whose signatures attest their acceptance of the above restrictions.

NAME AND ADDRESS	DATE